

By: Representative McGee

To: Medicaid

COMMITTEE SUBSTITUTE  
FOR  
HOUSE BILL NO. 1148

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,  
2 TO ALLOW THE FAMILY PLANNING WAIVER PROGRAM UNDER THE MEDICAID  
3 PROGRAM TO BE CONDUCTED UNDER A WAIVER OR THE STATE PLAN; TO  
4 PROVIDE THAT MEN OF REPRODUCTIVE AGE ARE ELIGIBLE UNDER THE FAMILY  
5 PLANNING PROGRAM; TO PROVIDE THAT CHILDREN IN STATE CUSTODY WHO  
6 ARE IN FOSTER CARE ON THEIR EIGHTEENTH BIRTHDAY SHALL BE MEDICAID  
7 ELIGIBLE UNTIL THEIR TWENTY SIXTH BIRTHDAY; TO PROVIDE THAT  
8 CHILDREN WHO HAVE AGED OUT OF FOSTER CARE WHILE ON MEDICAID IN  
9 OTHER STATES SHALL QUALIFY UNTIL THEIR TWENTY SIXTH BIRTHDAY; TO  
10 DELETE THE AUTHORITY FOR A WAIVER PROGRAM TO PROVIDE SERVICES TO  
11 CERTAIN INDIVIDUALS WHO ARE END STAGE RENAL DISEASE PATIENTS ON  
12 DIALYSIS, CANCER PATIENTS ON CHEMOTHERAPY OR ORGAN TRANSPLANT  
13 RECIPIENTS ON ANTIREJECTION DRUGS; TO AMEND SECTION 43-13-117,  
14 MISSISSIPPI CODE OF 1972, TO DELETE THE OPTION FOR CERTAIN RURAL  
15 HOSPITALS TO NOT BE REIMBURSED FOR OUTPATIENT HOSPITAL SERVICES  
16 USING THE APC METHODOLOGY; TO DIRECT THE DIVISION OF MEDICAID TO  
17 UPDATE THE CASE MIX PAYMENT SYSTEM FAIR RENTAL REIMBURSEMENT  
18 SYSTEM FOR NURSING FACILITY SERVICES AS NECESSARY TO MAINTAIN  
19 COMPLIANCE WITH FEDERAL LAW; TO AUTHORIZE THE DIVISION TO  
20 IMPLEMENT A QUALITY OR VALUE-BASED COMPONENT TO THE NURSING  
21 FACILITY PAYMENT SYSTEM; TO DELETE THE LEGISLATIVE INTENT FOR THE  
22 DIVISION TO ENCOURAGE THE USE OF ALPHA HYDROXYPROGESTERONE  
23 CAPROATE TO PREVENT RECURRENT PRETERM BIRTHS; TO AUTHORIZE ORAL  
24 CONTRACEPTIVES TO BE PRESCRIBED AND DISPENSED IN TWELVE MONTH  
25 SUPPLY INCREMENTS UNDER FAMILY PLANNING SERVICES; TO UPDATE AND  
26 CLARIFY LANGUAGE ABOUT THE DIVISION'S TRANSITION FROM THE MEDICARE  
27 UPPER PAYMENTS LIMITS (UPL) PROGRAM TO THE MISSISSIPPI HOSPITAL  
28 ACCESS PROGRAM (MHAP); TO PROVIDE THAT THE DIVISION SHALL MAXIMIZE  
29 TOTAL FEDERAL FUNDING FOR MHAP, UPL AND OTHER SUPPLEMENTAL PAYMENT  
30 PROGRAMS IN EFFECT FOR STATE FISCAL YEAR 2025 AND SHALL NOT CHANGE  
31 THE METHODOLOGIES, FORMULAS, MODELS OR PREPRINTS USED TO CALCULATE  
32 THE DISTRIBUTION OF SUPPLEMENTAL PAYMENTS TO HOSPITALS FROM THOSE  
33 METHODOLOGIES, FORMULAS, MODELS OR PREPRINTS IN EFFECT AND AS  
34 APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR



35 STATE FISCAL YEAR 2025; TO REQUIRE THAT POPULATIONS ELIGIBLE FOR  
36 RECEIVING PERINATAL RISK MANAGEMENT SERVICES FROM MANAGED CARE  
37 ORGANIZATIONS RECEIVE THE SERVICES FROM THE MANAGED CARE  
38 ORGANIZATIONS OR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH FOR  
39 THOSE SERVICES; TO REINSTATE THE AUTHORITY TO PROVIDE MEDICAID  
40 REIMBURSEMENT FOR A BORDER CITY UNIVERSITY AFFILIATED PEDIATRIC  
41 TEACHING HOSPITAL; TO LIMIT THE PAYMENT FOR PROVIDING SERVICES TO  
42 MISSISSIPPI MEDICAID BENEFICIARIES UNDER THE AGE OF TWENTY ONE  
43 YEARS WHO ARE TREATED BY A BORDER CITY UNIVERSITY AFFILIATED  
44 PEDIATRIC TEACHING HOSPITAL; TO EXTEND THE DATE OF THE REPEALER ON  
45 PROVIDING MEDICAID REIMBURSEMENT FOR A BORDER CITY UNIVERSITY  
46 AFFILIATED PEDIATRIC TEACHING HOSPITAL; TO AUTHORIZE THE DIVISION  
47 TO EXPEDITE NOTICE TO THE CHAIRMEN OF THE MEDICAID COMMITTEES WHEN  
48 THE DIVISION PROPOSES A RATE CHANGE; AMEND SECTION 43-13-121,  
49 MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION TO EXPEDITE  
50 NOTICE TO THE CHAIRMEN OF THE MEDICAID COMMITTEES WHEN THE  
51 DIVISION PROPOSES A STATE PLAN AMENDMENT; TO AMEND SECTION  
52 43-13-305, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT WHEN A THIRD  
53 PARTY PAYOR REQUIRES PRIOR AUTHORIZATION FOR AN ITEM OR SERVICE  
54 FURNISHED TO A MEDICAID RECIPIENT, THE PAYOR SHALL ACCEPT  
55 AUTHORIZATION PROVIDED BY THE DIVISION OF MEDICAID THAT THE ITEM  
56 OR SERVICE IS COVERED UNDER THE STATE PLAN AS IF SUCH  
57 AUTHORIZATION WERE THE PRIOR AUTHORIZATION MADE BY THE THIRD PARTY  
58 PAYOR FOR SUCH ITEM OR SERVICE; TO AMEND SECTION 43-13-107,  
59 MISSISSIPPI CODE OF 1972, TO ESTABLISH A MEDICAID ADVISORY  
60 COMMITTEE AND BENEFICIARY ADVISORY COMMITTEE AS REQUIRED PURSUANT  
61 TO FEDERAL REGULATIONS; TO PROVIDE THAT ALL MEMBERS OF THE MEDICAL  
62 CARE ADVISORY COMMITTEE SERVING ON JANUARY 1, 2025, SHALL BE  
63 SELECTED TO SERVE ON THE MEDICAID ADVISORY COMMITTEE AND SUCH  
64 MEMBERS SHALL SERVE UNTIL JULY 1, 2028; AND FOR RELATED PURPOSES.

65 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

66 **SECTION 1.** Section 43-13-115, Mississippi Code of 1972, is  
67 amended as follows:

68 43-13-115. Recipients of Medicaid shall be the following  
69 persons only:

70 (1) Those who are qualified for public assistance  
71 grants under provisions of Title IV-A and E of the federal Social  
72 Security Act, as amended, including those statutorily deemed to be  
73 IV-A and low income families and children under Section 1931 of  
74 the federal Social Security Act. For the purposes of this



75 paragraph (1) and paragraphs (8), (17) and (18) of this section,  
76 any reference to Title IV-A or to Part A of Title IV of the  
77 federal Social Security Act, as amended, or the state plan under  
78 Title IV-A or Part A of Title IV, shall be considered as a  
79 reference to Title IV-A of the federal Social Security Act, as  
80 amended, and the state plan under Title IV-A, including the income  
81 and resource standards and methodologies under Title IV-A and the  
82 state plan, as they existed on July 16, 1996. The Department of  
83 Human Services shall determine Medicaid eligibility for children  
84 receiving public assistance grants under Title IV-E. The division  
85 shall determine eligibility for low income families under Section  
86 1931 of the federal Social Security Act and shall redetermine  
87 eligibility for those continuing under Title IV-A grants.

88 (2) Those qualified for Supplemental Security Income  
89 (SSI) benefits under Title XVI of the federal Social Security Act,  
90 as amended, and those who are deemed SSI eligible as contained in  
91 federal statute. The eligibility of individuals covered in this  
92 paragraph shall be determined by the Social Security  
93 Administration and certified to the Division of Medicaid.

94 (3) Qualified pregnant women who would be eligible for  
95 Medicaid as a low income family member under Section 1931 of the  
96 federal Social Security Act if her child were born. The  
97 eligibility of the individuals covered under this paragraph shall  
98 be determined by the division.

99 (4) [Deleted]



100           (5) A child born on or after October 1, 1984, to a  
101 woman eligible for and receiving Medicaid under the state plan on  
102 the date of the child's birth shall be deemed to have applied for  
103 Medicaid and to have been found eligible for Medicaid under the  
104 plan on the date of that birth, and will remain eligible for  
105 Medicaid for a period of one (1) year so long as the child is a  
106 member of the woman's household and the woman remains eligible for  
107 Medicaid or would be eligible for Medicaid if pregnant. The  
108 eligibility of individuals covered in this paragraph shall be  
109 determined by the Division of Medicaid.

110           (6) Children certified by the State Department of Human  
111 Services to the Division of Medicaid of whom the state and county  
112 departments of human services have custody and financial  
113 responsibility, and children who are in adoptions subsidized in  
114 full or part by the Department of Human Services, including  
115 special needs children in non-Title IV-E adoption assistance, who  
116 are approvable under Title XIX of the Medicaid program. The  
117 eligibility of the children covered under this paragraph shall be  
118 determined by the State Department of Human Services.

119           (7) Persons certified by the Division of Medicaid who  
120 are patients in a medical facility (nursing home, hospital,  
121 tuberculosis sanatorium or institution for treatment of mental  
122 diseases), and who, except for the fact that they are patients in  
123 that medical facility, would qualify for grants under Title IV,  
124 Supplementary Security Income (SSI) benefits under Title XVI or



125 state supplements, and those aged, blind and disabled persons who  
126 would not be eligible for Supplemental Security Income (SSI)  
127 benefits under Title XVI or state supplements if they were not  
128 institutionalized in a medical facility but whose income is below  
129 the maximum standard set by the Division of Medicaid, which  
130 standard shall not exceed that prescribed by federal regulation.

131 (8) Children under eighteen (18) years of age and  
132 pregnant women (including those in intact families) who meet the  
133 financial standards of the state plan approved under Title IV-A of  
134 the federal Social Security Act, as amended. The eligibility of  
135 children covered under this paragraph shall be determined by the  
136 Division of Medicaid.

137 (9) Individuals who are:

138 (a) Children born after September 30,  
139 1983, \* \* \* ~~who have not attained the age of~~ between the age of six  
140 (6) and nineteen (19), with family income that does not  
141 exceed \* \* \* ~~one hundred percent (100%)~~ one hundred thirty-three  
142 percent (133%) of the \* \* \* ~~nonfarm official~~ federal poverty level;

143 (b) Pregnant women, infants and children \* \* \* ~~who~~  
144 ~~have not attained the age of~~ between the age of one (1) and six  
145 (6), with family income that does not exceed \* \* \* ~~one hundred~~  
146 ~~thirty-three percent (133%)~~ one hundred forty-three percent (143%)  
147 of the federal poverty level; and

148 (c) Pregnant women and infants who have not  
149 attained the age of one (1), with family income that does not



150 exceed \* \* \*~~one hundred eighty-five percent (185%)~~ one hundred  
151 ninety-four percent (194%) of the federal poverty level.

152 The eligibility of individuals covered in (a), (b) and (c) of  
153 this paragraph shall be determined by the division.

154 (10) Certain disabled children age eighteen (18) or  
155 under who are living at home, who would be eligible, if in a  
156 medical institution, for SSI or a state supplemental payment under  
157 Title XVI of the federal Social Security Act, as amended, and  
158 therefore for Medicaid under the plan, and for whom the state has  
159 made a determination as required under Section 1902(e)(3)(b) of  
160 the federal Social Security Act, as amended. The eligibility of  
161 individuals under this paragraph shall be determined by the  
162 Division of Medicaid.

163 (11) \* \* \*~~Until the end of the day on December 31,~~  
164 ~~2005,~~ Individuals who are sixty-five (65) years of age or older or  
165 are disabled as determined under Section 1614(a)(3) of the federal  
166 Social Security Act, as amended, and whose income does not exceed  
167 one hundred thirty-five percent (135%) of the \* \* \*~~nonfarm~~  
168 ~~official federal~~ federal poverty level \* \* \*~~as defined by the Office of~~  
169 ~~Management and Budget and revised annually,~~ and whose resources do  
170 not exceed those established by the Division of Medicaid. The  
171 eligibility of individuals covered under this paragraph shall be  
172 determined by the Division of Medicaid. \* \* \*~~After December 31,~~  
173 ~~2005,~~ Only those individuals covered under the 1115(c) Healthier  
174 Mississippi waiver will be covered under this category.



175 Any individual who applied for Medicaid during the period  
176 from July 1, 2004, through March 31, 2005, who otherwise would  
177 have been eligible for coverage under this paragraph (11) if it  
178 had been in effect at the time the individual submitted his or her  
179 application and is still eligible for coverage under this  
180 paragraph (11) on March 31, 2005, shall be eligible for Medicaid  
181 coverage under this paragraph (11) from March 31, 2005, through  
182 December 31, 2005. The division shall give priority in processing  
183 the applications for those individuals to determine their  
184 eligibility under this paragraph (11).

185 (12) Individuals who are qualified Medicare  
186 beneficiaries (QMB) entitled to Part A Medicare as defined under  
187 Section 301, Public Law 100-360, known as the Medicare  
188 Catastrophic Coverage Act of 1988, and whose income does not  
189 exceed one hundred percent (100%) of the \* \* \*~~nonfarm official~~  
190 federal poverty level \* \* \*~~as defined by the Office of Management~~  
191 ~~and Budget and revised annually.~~

192 The eligibility of individuals covered under this paragraph  
193 shall be determined by the Division of Medicaid, and those  
194 individuals determined eligible shall receive Medicare  
195 cost-sharing expenses only as more fully defined by the Medicare  
196 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of  
197 1997.

198 (13) (a) Individuals who are entitled to Medicare Part  
199 A as defined in Section 4501 of the Omnibus Budget Reconciliation



200 Act of 1990, and whose income does not exceed one hundred twenty  
201 percent (120%) of the \* \* \*~~nonfarm official~~ federal poverty  
202 level \* \* \*~~as defined by the Office of Management and Budget and~~  
203 ~~revised annually~~. Eligibility for Medicaid benefits is limited to  
204 full payment of Medicare Part B premiums.

205 (b) Individuals entitled to Part A of Medicare,  
206 with income above one hundred twenty percent (120%), but less than  
207 one hundred thirty-five percent (135%) of the federal poverty  
208 level, and not otherwise eligible for Medicaid. Eligibility for  
209 Medicaid benefits is limited to full payment of Medicare Part B  
210 premiums. The number of eligible individuals is limited by the  
211 availability of the federal capped allocation at one hundred  
212 percent (100%) of federal matching funds, as more fully defined in  
213 the Balanced Budget Act of 1997.

214 The eligibility of individuals covered under this paragraph  
215 shall be determined by the Division of Medicaid.

216 (14) [Deleted]

217 (15) Disabled workers who are eligible to enroll in  
218 Part A Medicare as required by Public Law 101-239, known as the  
219 Omnibus Budget Reconciliation Act of 1989, and whose income does  
220 not exceed two hundred percent (200%) of the federal poverty level  
221 as determined in accordance with the Supplemental Security Income  
222 (SSI) program. The eligibility of individuals covered under this  
223 paragraph shall be determined by the Division of Medicaid and





224 those individuals shall be entitled to buy-in coverage of Medicare  
225 Part A premiums only under the provisions of this paragraph (15).

226 (16) In accordance with the terms and conditions of  
227 approved Title XIX waiver from the United States Department of  
228 Health and Human Services, persons provided home- and  
229 community-based services who are physically disabled and certified  
230 by the Division of Medicaid as eligible due to applying the income  
231 and deeming requirements as if they were institutionalized.

232 (17) In accordance with the terms of the federal  
233 Personal Responsibility and Work Opportunity Reconciliation Act of  
234 1996 (Public Law 104-193), persons who become ineligible for  
235 assistance under Title IV-A of the federal Social Security Act, as  
236 amended, because of increased income from or hours of employment  
237 of the caretaker relative or because of the expiration of the  
238 applicable earned income disregards, who were eligible for  
239 Medicaid for at least three (3) of the six (6) months preceding  
240 the month in which the ineligibility begins, shall be eligible for  
241 Medicaid for up to twelve (12) months. The eligibility of the  
242 individuals covered under this paragraph shall be determined by  
243 the division.

244 (18) Persons who become ineligible for assistance under  
245 Title IV-A of the federal Social Security Act, as amended, as a  
246 result, in whole or in part, of the collection or increased  
247 collection of child or spousal support under Title IV-D of the  
248 federal Social Security Act, as amended, who were eligible for



249 Medicaid for at least three (3) of the six (6) months immediately  
250 preceding the month in which the ineligibility begins, shall be  
251 eligible for Medicaid for an additional four (4) months beginning  
252 with the month in which the ineligibility begins. The eligibility  
253 of the individuals covered under this paragraph shall be  
254 determined by the division.

255 (19) Disabled workers, whose incomes are above the  
256 Medicaid eligibility limits, but below two hundred fifty percent  
257 (250%) of the federal poverty level, shall be allowed to purchase  
258 Medicaid coverage on a sliding fee scale developed by the Division  
259 of Medicaid.

260 (20) Medicaid eligible children under age eighteen (18)  
261 shall remain eligible for Medicaid benefits until the end of a  
262 period of twelve (12) months following an eligibility  
263 determination, or until such time that the individual exceeds age  
264 eighteen (18).

265 (21) Women and men of \* \* \*~~childbearing~~ reproductive  
266 age whose family income does not exceed \* \* \*~~one hundred~~  
267 ~~eighty-five percent (185%)~~ one hundred ninety-four percent (194%)  
268 of the federal poverty level. The eligibility of individuals  
269 covered under this paragraph (21) shall be determined by the  
270 Division of Medicaid, and those individuals determined eligible  
271 shall only receive family planning services covered under Section  
272 43-13-117(13) and not any other services covered under Medicaid.  
273 However, any individual eligible under this paragraph (21) who is



274 also eligible under any other provision of this section shall  
275 receive the benefits to which he or she is entitled under that  
276 other provision, in addition to family planning services covered  
277 under Section 43-13-117(13).

278 The Division of Medicaid \* \* \* ~~shall~~ may apply to the United  
279 States Secretary of Health and Human Services for a federal waiver  
280 of the applicable provisions of Title XIX of the federal Social  
281 Security Act, as amended, and any other applicable provisions of  
282 federal law as necessary to allow for the implementation of this  
283 paragraph (21). \* \* \* ~~The provisions of this paragraph (21)~~  
284 ~~shall be implemented from and after the date that the Division of~~  
285 ~~Medicaid receives the federal waiver.~~

286 (22) Persons who are workers with a potentially severe  
287 disability, as determined by the division, shall be allowed to  
288 purchase Medicaid coverage. The term "worker with a potentially  
289 severe disability" means a person who is at least sixteen (16)  
290 years of age but under sixty-five (65) years of age, who has a  
291 physical or mental impairment that is reasonably expected to cause  
292 the person to become blind or disabled as defined under Section  
293 1614(a) of the federal Social Security Act, as amended, if the  
294 person does not receive items and services provided under  
295 Medicaid.

296 The eligibility of persons under this paragraph (22) shall be  
297 conducted as a demonstration project that is consistent with  
298 Section 204 of the Ticket to Work and Work Incentives Improvement



299 Act of 1999, Public Law 106-170, for a certain number of persons  
300 as specified by the division. The eligibility of individuals  
301 covered under this paragraph (22) shall be determined by the  
302 Division of Medicaid.

303 (23) Children certified by the Mississippi Department  
304 of Human Services for whom the state and county departments of  
305 human services have custody and financial responsibility who are  
306 in foster care on their eighteenth birthday as reported by the  
307 Mississippi Department of Human Services shall be certified  
308 Medicaid eligible by the Division of Medicaid until  
309 their \* \* \*~~twenty-first~~ twenty-sixth birthday. Children who have  
310 aged out of foster care while on Medicaid in other states shall  
311 qualify until their twenty-sixth birthday.

312 (24) Individuals who have not attained age sixty-five  
313 (65), are not otherwise covered by creditable coverage as defined  
314 in the Public Health Services Act, and have been screened for  
315 breast and cervical cancer under the Centers for Disease Control  
316 and Prevention Breast and Cervical Cancer Early Detection Program  
317 established under Title XV of the Public Health Service Act in  
318 accordance with the requirements of that act and who need  
319 treatment for breast or cervical cancer. Eligibility of  
320 individuals under this paragraph (24) shall be determined by the  
321 Division of Medicaid.

322 (25) The division shall apply to the Centers for  
323 Medicare and Medicaid Services (CMS) for any necessary waivers to



324 provide services to individuals who are sixty-five (65) years of  
325 age or older or are disabled as determined under Section  
326 1614(a)(3) of the federal Social Security Act, as amended, and  
327 whose income does not exceed one hundred thirty-five percent  
328 (135%) of the \* \* \*~~nonfarm official~~ federal poverty level \* \* \*~~as~~  
329 ~~defined by the Office of Management and Budget and revised~~  
330 ~~annually,~~ and whose resources do not exceed those established by  
331 the Division of Medicaid, and who are not otherwise covered by  
332 Medicare. Nothing contained in this paragraph (25) shall entitle  
333 an individual to benefits. The eligibility of individuals covered  
334 under this paragraph shall be determined by the Division of  
335 Medicaid.

336 (26) \* \* \*~~The division shall apply to the Centers for~~  
337 ~~Medicare and Medicaid Services (CMS) for any necessary waivers to~~  
338 ~~provide services to individuals who are sixty-five (65) years of~~  
339 ~~age or older or are disabled as determined under Section~~  
340 ~~1614(a)(3) of the federal Social Security Act, as amended, who are~~  
341 ~~end stage renal disease patients on dialysis, cancer patients on~~  
342 ~~chemotherapy or organ transplant recipients on antirejection~~  
343 ~~drugs, whose income does not exceed one hundred thirty-five~~  
344 ~~percent (135%) of the nonfarm official poverty level as defined by~~  
345 ~~the Office of Management and Budget and revised annually, and~~  
346 ~~whose resources do not exceed those established by the division.~~  
347 ~~Nothing contained in this paragraph (26) shall entitle an~~  
348 ~~individual to benefits. The eligibility of individuals covered~~



349 ~~under this paragraph shall be determined by the Division of~~  
350 ~~Medicaid.~~ [Deleted]

351 (27) Individuals who are entitled to Medicare Part D  
352 and whose income does not exceed one hundred fifty percent (150%)  
353 of the \* \* \*~~nonfarm official~~ federal poverty level \* \* \*~~as~~  
354 ~~defined by the Office of Management and Budget and revised~~  
355 ~~annually.~~ Eligibility for payment of the Medicare Part D subsidy  
356 under this paragraph shall be determined by the division.

357 (28) The division is authorized and directed to provide  
358 up to twelve (12) months of continuous coverage postpartum for any  
359 individual who qualifies for Medicaid coverage under this section  
360 as a pregnant woman, to the extent allowable under federal law and  
361 as determined by the division.

362 The division shall redetermine eligibility for all categories  
363 of recipients described in each paragraph of this section not less  
364 frequently than required by federal law.

365 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is  
366 amended as follows:

367 43-13-117. (A) Medicaid as authorized by this article shall  
368 include payment of part or all of the costs, at the discretion of  
369 the division, with approval of the Governor and the Centers for  
370 Medicare and Medicaid Services, of the following types of care and  
371 services rendered to eligible applicants who have been determined  
372 to be eligible for that care and services, within the limits of  
373 state appropriations and federal matching funds:



374 (1) Inpatient hospital services.

375 (a) The division is authorized to implement an All  
376 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement  
377 methodology for inpatient hospital services.

378 (b) No service benefits or reimbursement  
379 limitations in this subsection (A) (1) shall apply to payments  
380 under an APR-DRG or Ambulatory Payment Classification (APC) model  
381 or a managed care program or similar model described in subsection  
382 (H) of this section unless specifically authorized by the  
383 division.

384 (2) Outpatient hospital services.

385 (a) Emergency services.

386 (b) Other outpatient hospital services. The  
387 division shall allow benefits for other medically necessary  
388 outpatient hospital services (such as chemotherapy, radiation,  
389 surgery and therapy), including outpatient services in a clinic or  
390 other facility that is not located inside the hospital, but that  
391 has been designated as an outpatient facility by the hospital, and  
392 that was in operation or under construction on July 1, 2009,  
393 provided that the costs and charges associated with the operation  
394 of the hospital clinic are included in the hospital's cost report.  
395 In addition, the Medicare thirty-five-mile rule will apply to  
396 those hospital clinics not located inside the hospital that are  
397 constructed after July 1, 2009. Where the same services are  
398 reimbursed as clinic services, the division may revise the rate or



399 methodology of outpatient reimbursement to maintain consistency,  
400 efficiency, economy and quality of care.

401 (c) The division is authorized to implement an  
402 Ambulatory Payment Classification (APC) methodology for outpatient  
403 hospital services. \* \* \* ~~The division shall give rural hospitals~~  
404 ~~that have fifty (50) or fewer licensed beds the option to not be~~  
405 ~~reimbursed for outpatient hospital services using the APC~~  
406 ~~methodology, but reimbursement for outpatient hospital services~~  
407 ~~provided by those hospitals shall be based on one hundred one~~  
408 ~~percent (101%) of the rate established under Medicare for~~  
409 ~~outpatient hospital services. Those hospitals choosing to not be~~  
410 ~~reimbursed under the APC methodology shall remain under cost-based~~  
411 ~~reimbursement for a two-year period.~~

412 (d) No service benefits or reimbursement  
413 limitations in this subsection (A) (2) shall apply to payments  
414 under an APR-DRG or APC model or a managed care program or similar  
415 model described in subsection (H) of this section unless  
416 specifically authorized by the division.

417 (3) Laboratory and x-ray services.

418 (4) Nursing facility services.

419 (a) The division shall make full payment to  
420 nursing facilities for each day, not exceeding forty-two (42) days  
421 per year, that a patient is absent from the facility on home  
422 leave. Payment may be made for the following home leave days in  
423 addition to the forty-two-day limitation: Christmas, the day





424 before Christmas, the day after Christmas, Thanksgiving, the day  
425 before Thanksgiving and the day after Thanksgiving.

426 (b) From and after July 1, 1997, the division  
427 shall implement the integrated case-mix payment and quality  
428 monitoring system, which includes the fair rental system for  
429 property costs and in which recapture of depreciation is  
430 eliminated. The division may reduce the payment for hospital  
431 leave and therapeutic home leave days to the lower of the case-mix  
432 category as computed for the resident on leave using the  
433 assessment being utilized for payment at that point in time, or a  
434 case-mix score of 1.000 for nursing facilities, and shall compute  
435 case-mix scores of residents so that only services provided at the  
436 nursing facility are considered in calculating a facility's per  
437 diem.

438 (c) From and after July 1, 1997, all state-owned  
439 nursing facilities shall be reimbursed on a full reasonable cost  
440 basis.

441 (d) \* \* \*~~On or after January 1, 2015,~~ The division  
442 shall update the case-mix payment system \* \* \*~~resource utilization~~  
443 ~~grouping and classifications~~ and fair rental reimbursement system  
444 as necessary to maintain compliance with federal law. The  
445 division shall develop and implement a payment add-on to reimburse  
446 nursing facilities for ventilator-dependent resident services.

447 (e) The division shall develop and implement, not  
448 later than January 1, 2001, a case-mix payment add-on determined



449 by time studies and other valid statistical data that will  
450 reimburse a nursing facility for the additional cost of caring for  
451 a resident who has a diagnosis of Alzheimer's or other related  
452 dementia and exhibits symptoms that require special care. Any  
453 such case-mix add-on payment shall be supported by a determination  
454 of additional cost. The division shall also develop and implement  
455 as part of the fair rental reimbursement system for nursing  
456 facility beds, an Alzheimer's resident bed depreciation enhanced  
457 reimbursement system that will provide an incentive to encourage  
458 nursing facilities to convert or construct beds for residents with  
459 Alzheimer's or other related dementia.

460 (f) The division shall develop and implement an  
461 assessment process for long-term care services. The division may  
462 provide the assessment and related functions directly or through  
463 contract with the area agencies on aging.

464 (g) The division may implement a quality or  
465 value-based component to the nursing facility payment system.

466 The division shall apply for necessary federal waivers to  
467 assure that additional services providing alternatives to nursing  
468 facility care are made available to applicants for nursing  
469 facility care.

470 (5) Periodic screening and diagnostic services for  
471 individuals under age twenty-one (21) years as are needed to  
472 identify physical and mental defects and to provide health care  
473 treatment and other measures designed to correct or ameliorate



474 defects and physical and mental illness and conditions discovered  
475 by the screening services, regardless of whether these services  
476 are included in the state plan. The division may include in its  
477 periodic screening and diagnostic program those discretionary  
478 services authorized under the federal regulations adopted to  
479 implement Title XIX of the federal Social Security Act, as  
480 amended. The division, in obtaining physical therapy services,  
481 occupational therapy services, and services for individuals with  
482 speech, hearing and language disorders, may enter into a  
483 cooperative agreement with the State Department of Education for  
484 the provision of those services to handicapped students by public  
485 school districts using state funds that are provided from the  
486 appropriation to the Department of Education to obtain federal  
487 matching funds through the division. The division, in obtaining  
488 medical and mental health assessments, treatment, care and  
489 services for children who are in, or at risk of being put in, the  
490 custody of the Mississippi Department of Human Services may enter  
491 into a cooperative agreement with the Mississippi Department of  
492 Human Services for the provision of those services using state  
493 funds that are provided from the appropriation to the Department  
494 of Human Services to obtain federal matching funds through the  
495 division.

496 (6) Physician services. Fees for physician's services  
497 that are covered only by Medicaid shall be reimbursed at ninety  
498 percent (90%) of the rate established on January 1, 2018, and as



499 may be adjusted each July thereafter, under Medicare. The  
500 division may provide for a reimbursement rate for physician's  
501 services of up to one hundred percent (100%) of the rate  
502 established under Medicare for physician's services that are  
503 provided after the normal working hours of the physician, as  
504 determined in accordance with regulations of the division. The  
505 division may reimburse eligible providers, as determined by the  
506 division, for certain primary care services at one hundred percent  
507 (100%) of the rate established under Medicare. The division shall  
508 reimburse obstetricians and gynecologists for certain primary care  
509 services as defined by the division at one hundred percent (100%)  
510 of the rate established under Medicare.

511 (7) (a) Home health services for eligible persons, not  
512 to exceed in cost the prevailing cost of nursing facility  
513 services. All home health visits must be precertified as required  
514 by the division. In addition to physicians, certified registered  
515 nurse practitioners, physician assistants and clinical nurse  
516 specialists are authorized to prescribe or order home health  
517 services and plans of care, sign home health plans of care,  
518 certify and recertify eligibility for home health services and  
519 conduct the required initial face-to-face visit with the recipient  
520 of the services.

521 (b) [Repealed]

522 (8) Emergency medical transportation services as  
523 determined by the division.



524 (9) Prescription drugs and other covered drugs and  
525 services as determined by the division.

526 The division shall establish a mandatory preferred drug list.  
527 Drugs not on the mandatory preferred drug list shall be made  
528 available by utilizing prior authorization procedures established  
529 by the division.

530 The division may seek to establish relationships with other  
531 states in order to lower acquisition costs of prescription drugs  
532 to include single-source and innovator multiple-source drugs or  
533 generic drugs. In addition, if allowed by federal law or  
534 regulation, the division may seek to establish relationships with  
535 and negotiate with other countries to facilitate the acquisition  
536 of prescription drugs to include single-source and innovator  
537 multiple-source drugs or generic drugs, if that will lower the  
538 acquisition costs of those prescription drugs.

539 The division may allow for a combination of prescriptions for  
540 single-source and innovator multiple-source drugs and generic  
541 drugs to meet the needs of the beneficiaries.

542 The executive director may approve specific maintenance drugs  
543 for beneficiaries with certain medical conditions, which may be  
544 prescribed and dispensed in three-month supply increments.

545 Drugs prescribed for a resident of a psychiatric residential  
546 treatment facility must be provided in true unit doses when  
547 available. The division may require that drugs not covered by  
548 Medicare Part D for a resident of a long-term care facility be



549 provided in true unit doses when available. Those drugs that were  
550 originally billed to the division but are not used by a resident  
551 in any of those facilities shall be returned to the billing  
552 pharmacy for credit to the division, in accordance with the  
553 guidelines of the State Board of Pharmacy and any requirements of  
554 federal law and regulation. Drugs shall be dispensed to a  
555 recipient and only one (1) dispensing fee per month may be  
556 charged. The division shall develop a methodology for reimbursing  
557 for restocked drugs, which shall include a restock fee as  
558 determined by the division not exceeding Seven Dollars and  
559 Eighty-two Cents (\$7.82).

560 Except for those specific maintenance drugs approved by the  
561 executive director, the division shall not reimburse for any  
562 portion of a prescription that exceeds a thirty-one-day supply of  
563 the drug based on the daily dosage.

564 The division is authorized to develop and implement a program  
565 of payment for additional pharmacist services as determined by the  
566 division.

567 All claims for drugs for dually eligible Medicare/Medicaid  
568 beneficiaries that are paid for by Medicare must be submitted to  
569 Medicare for payment before they may be processed by the  
570 division's online payment system.

571 The division shall develop a pharmacy policy in which drugs  
572 in tamper-resistant packaging that are prescribed for a resident  
573 of a nursing facility but are not dispensed to the resident shall



574 be returned to the pharmacy and not billed to Medicaid, in  
575 accordance with guidelines of the State Board of Pharmacy.

576 The division shall develop and implement a method or methods  
577 by which the division will provide on a regular basis to Medicaid  
578 providers who are authorized to prescribe drugs, information about  
579 the costs to the Medicaid program of single-source drugs and  
580 innovator multiple-source drugs, and information about other drugs  
581 that may be prescribed as alternatives to those single-source  
582 drugs and innovator multiple-source drugs and the costs to the  
583 Medicaid program of those alternative drugs.

584 Notwithstanding any law or regulation, information obtained  
585 or maintained by the division regarding the prescription drug  
586 program, including trade secrets and manufacturer or labeler  
587 pricing, is confidential and not subject to disclosure except to  
588 other state agencies.

589 The dispensing fee for each new or refill prescription,  
590 including nonlegend or over-the-counter drugs covered by the  
591 division, shall be not less than Three Dollars and Ninety-one  
592 Cents (\$3.91), as determined by the division.

593 The division shall not reimburse for single-source or  
594 innovator multiple-source drugs if there are equally effective  
595 generic equivalents available and if the generic equivalents are  
596 the least expensive.



597 It is the intent of the Legislature that the pharmacists  
598 providers be reimbursed for the reasonable costs of filling and  
599 dispensing prescriptions for Medicaid beneficiaries.

600 The division shall allow certain drugs, including  
601 physician-administered drugs, and implantable drug system devices,  
602 and medical supplies, with limited distribution or limited access  
603 for beneficiaries and administered in an appropriate clinical  
604 setting, to be reimbursed as either a medical claim or pharmacy  
605 claim, as determined by the division.

606 \* \* \* ~~It is the intent of the Legislature that the division  
607 and any managed care entity described in subsection (H) of this  
608 section encourage the use of Alpha-Hydroxyprogesterone Caproate  
609 (17P) to prevent recurrent preterm birth.~~

610 (10) Dental and orthodontic services to be determined  
611 by the division.

612 The division shall increase the amount of the reimbursement  
613 rate for diagnostic and preventative dental services for each of  
614 the fiscal years 2022, 2023 and 2024 by five percent (5%) above  
615 the amount of the reimbursement rate for the previous fiscal year.  
616 The division shall increase the amount of the reimbursement rate  
617 for restorative dental services for each of the fiscal years 2023,  
618 2024 and 2025 by five percent (5%) above the amount of the  
619 reimbursement rate for the previous fiscal year. It is the intent  
620 of the Legislature that the reimbursement rate revision for  
621 preventative dental services will be an incentive to increase the





622 number of dentists who actively provide Medicaid services. This  
623 dental services reimbursement rate revision shall be known as the  
624 "James Russell Dumas Medicaid Dental Services Incentive Program."

625 The Medical Care Advisory Committee, assisted by the Division  
626 of Medicaid, shall annually determine the effect of this incentive  
627 by evaluating the number of dentists who are Medicaid providers,  
628 the number who and the degree to which they are actively billing  
629 Medicaid, the geographic trends of where dentists are offering  
630 what types of Medicaid services and other statistics pertinent to  
631 the goals of this legislative intent. This data shall annually be  
632 presented to the Chair of the Senate Medicaid Committee and the  
633 Chair of the House Medicaid Committee.

634 The division shall include dental services as a necessary  
635 component of overall health services provided to children who are  
636 eligible for services.

637 (11) Eyeglasses for all Medicaid beneficiaries who have  
638 (a) had surgery on the eyeball or ocular muscle that results in a  
639 vision change for which eyeglasses or a change in eyeglasses is  
640 medically indicated within six (6) months of the surgery and is in  
641 accordance with policies established by the division, or (b) one  
642 (1) pair every five (5) years and in accordance with policies  
643 established by the division. In either instance, the eyeglasses  
644 must be prescribed by a physician skilled in diseases of the eye  
645 or an optometrist, whichever the beneficiary may select.

646 (12) Intermediate care facility services.



647 (a) The division shall make full payment to all  
648 intermediate care facilities for individuals with intellectual  
649 disabilities for each day, not exceeding sixty-three (63) days per  
650 year, that a patient is absent from the facility on home leave.  
651 Payment may be made for the following home leave days in addition  
652 to the sixty-three-day limitation: Christmas, the day before  
653 Christmas, the day after Christmas, Thanksgiving, the day before  
654 Thanksgiving and the day after Thanksgiving.

655 (b) All state-owned intermediate care facilities  
656 for individuals with intellectual disabilities shall be reimbursed  
657 on a full reasonable cost basis.

658 (c) Effective January 1, 2015, the division shall  
659 update the fair rental reimbursement system for intermediate care  
660 facilities for individuals with intellectual disabilities.

661 (13) Family planning services, including drugs,  
662 supplies and devices, when those services are under the  
663 supervision of a physician or nurse practitioner. Oral  
664 contraceptives may be prescribed and dispensed in twelve-month  
665 supply increments.

666 (14) Clinic services. Preventive, diagnostic,  
667 therapeutic, rehabilitative or palliative services that are  
668 furnished by a facility that is not part of a hospital but is  
669 organized and operated to provide medical care to outpatients.  
670 Clinic services include, but are not limited to:



671 (a) Services provided by ambulatory surgical  
672 centers (ACSS) as defined in Section 41-75-1(a); and

673 (b) Dialysis center services.

674 (15) Home- and community-based services for the elderly  
675 and disabled, as provided under Title XIX of the federal Social  
676 Security Act, as amended, under waivers, subject to the  
677 availability of funds specifically appropriated for that purpose  
678 by the Legislature.

679 (16) Mental health services. Certain services provided  
680 by a psychiatrist shall be reimbursed at up to one hundred percent  
681 (100%) of the Medicare rate. Approved therapeutic and case  
682 management services (a) provided by an approved regional mental  
683 health/intellectual disability center established under Sections  
684 41-19-31 through 41-19-39, or by another community mental health  
685 service provider meeting the requirements of the Department of  
686 Mental Health to be an approved mental health/intellectual  
687 disability center if determined necessary by the Department of  
688 Mental Health, using state funds that are provided in the  
689 appropriation to the division to match federal funds, or (b)  
690 provided by a facility that is certified by the State Department  
691 of Mental Health to provide therapeutic and case management  
692 services, to be reimbursed on a fee for service basis, or (c)  
693 provided in the community by a facility or program operated by the  
694 Department of Mental Health. Any such services provided by a



695 facility described in subparagraph (b) must have the prior  
696 approval of the division to be reimbursable under this section.

697 (17) Durable medical equipment services and medical  
698 supplies. Precertification of durable medical equipment and  
699 medical supplies must be obtained as required by the division.  
700 The Division of Medicaid may require durable medical equipment  
701 providers to obtain a surety bond in the amount and to the  
702 specifications as established by the Balanced Budget Act of 1997.  
703 A maximum dollar amount of reimbursement for noninvasive  
704 ventilators or ventilation treatments properly ordered and being  
705 used in an appropriate care setting shall not be set by any health  
706 maintenance organization, coordinated care organization,  
707 provider-sponsored health plan, or other organization paid for  
708 services on a capitated basis by the division under any managed  
709 care program or coordinated care program implemented by the  
710 division under this section. Reimbursement by these organizations  
711 to durable medical equipment suppliers for home use of noninvasive  
712 and invasive ventilators shall be on a continuous monthly payment  
713 basis for the duration of medical need throughout a patient's  
714 valid prescription period.

715 (18) (a) Notwithstanding any other provision of this  
716 section to the contrary, as provided in the Medicaid state plan  
717 amendment or amendments as defined in Section 43-13-145(10), the  
718 division shall make additional reimbursement to hospitals that  
719 serve a disproportionate share of low-income patients and that



720 meet the federal requirements for those payments as provided in  
721 Section 1923 of the federal Social Security Act and any applicable  
722 regulations. It is the intent of the Legislature that the  
723 division shall draw down all available federal funds allotted to  
724 the state for disproportionate share hospitals. However, from and  
725 after January 1, 1999, public hospitals participating in the  
726 Medicaid disproportionate share program may be required to  
727 participate in an intergovernmental transfer program as provided  
728 in Section 1903 of the federal Social Security Act and any  
729 applicable regulations.

730 (b) (i) 1. The division may establish a Medicare  
731 Upper Payment Limits Program, as defined in Section 1902(a)(30) of  
732 the federal Social Security Act and any applicable federal  
733 regulations, or an allowable delivery system or provider payment  
734 initiative authorized under 42 CFR 438.6(c), for hospitals,  
735 nursing facilities and physicians employed or contracted by  
736 hospitals.

737 2. The division shall establish a  
738 Medicaid Supplemental Payment Program, as permitted by the federal  
739 Social Security Act and a comparable allowable delivery system or  
740 provider payment initiative authorized under 42 CFR 438.6(c), for  
741 emergency ambulance transportation providers in accordance with  
742 this subsection (A)(18)(b).

743 (ii) The division shall assess each hospital,  
744 nursing facility, and emergency ambulance transportation provider



745 for the sole purpose of financing the state portion of the  
746 Medicare Upper Payment Limits Program or other program(s)  
747 authorized under this subsection (A) (18) (b). The hospital  
748 assessment shall be as provided in Section 43-13-145(4) (a), and  
749 the nursing facility and the emergency ambulance transportation  
750 assessments, if established, shall be based on Medicaid  
751 utilization or other appropriate method, as determined by the  
752 division, consistent with federal regulations. The assessments  
753 will remain in effect as long as the state participates in the  
754 Medicare Upper Payment Limits Program or other program(s)  
755 authorized under this subsection (A) (18) (b). In addition to the  
756 hospital assessment provided in Section 43-13-145(4) (a), hospitals  
757 with physicians participating in the Medicare Upper Payment Limits  
758 Program or other program(s) authorized under this subsection  
759 (A) (18) (b) shall be required to participate in an  
760 intergovernmental transfer or assessment, as determined by the  
761 division, for the purpose of financing the state portion of the  
762 physician UPL payments or other payment(s) authorized under this  
763 subsection (A) (18) (b).

764 (iii) Subject to approval by the Centers for  
765 Medicare and Medicaid Services (CMS) and the provisions of this  
766 subsection (A) (18) (b), the division shall make additional  
767 reimbursement to hospitals, nursing facilities, and emergency  
768 ambulance transportation providers for the Medicare Upper Payment  
769 Limits Program or other program(s) authorized under this



770 subsection (A) (18) (b), and, if the program is established for  
771 physicians, shall make additional reimbursement for physicians, as  
772 defined in Section 1902(a) (30) of the federal Social Security Act  
773 and any applicable federal regulations, provided the assessment in  
774 this subsection (A) (18) (b) is in effect.

775 (iv) \* \* \* ~~Notwithstanding any other provision~~  
776 ~~of this article to the contrary, effective upon implementation of~~  
777 ~~the Mississippi Hospital Access Program (MHAP) provided in~~  
778 ~~subparagraph (c) (i) below, the hospital portion of the inpatient~~  
779 ~~Upper Payment Limits Program shall transition into and be replaced~~  
780 ~~by the MHAP program. However, The division is authorized to~~  
781 ~~develop and implement an alternative fee-for-service Upper Payment~~  
782 ~~Limits model in accordance with federal laws and regulations if~~  
783 ~~necessary to preserve supplemental funding. \* \* \* Further, the~~  
784 ~~division, in consultation with the hospital industry shall develop~~  
785 ~~alternative models for distribution of medical claims and~~  
786 ~~supplemental payments for inpatient and outpatient hospital~~  
787 ~~services, and such models may include, but shall not be limited to~~  
788 ~~the following: increasing rates for inpatient and outpatient~~  
789 ~~services; creating a low-income utilization pool of funds to~~  
790 ~~reimburse hospitals for the costs of uncompensated care, charity~~  
791 ~~care and bad debts as permitted and approved pursuant to federal~~  
792 ~~regulations and the Centers for Medicare and Medicaid Services;~~  
793 ~~supplemental payments based upon Medicaid utilization, quality,~~  
794 ~~service lines and/or costs of providing such services to Medicaid~~



795 ~~beneficiaries and to uninsured patients. The goals of such~~  
796 ~~payment models shall be to ensure access to inpatient and~~  
797 ~~outpatient care and to maximize any federal funds that are~~  
798 ~~available to reimburse hospitals for services provided. Any such~~  
799 ~~documents required to achieve the goals described in this~~  
800 ~~paragraph shall be submitted to the Centers for Medicare and~~  
801 ~~Medicaid Services, with a proposed effective date of July 1, 2019,~~  
802 ~~to the extent possible, but in no event shall the effective date~~  
803 ~~of such payment models be later than July 1, 2020. The Chairmen~~  
804 ~~of the Senate and House Medicaid Committees shall be provided a~~  
805 ~~copy of the proposed payment model(s) prior to submission.~~  
806 ~~Effective July 1, 2018, and until such time as any payment~~  
807 ~~model(s) as described above become effective, the division, in~~  
808 ~~consultation with the hospital industry, is authorized to~~  
809 ~~implement a transitional program for inpatient and outpatient~~  
810 ~~payments and/or supplemental payments (including, but not limited~~  
811 ~~to, MHAP and directed payments), to redistribute available~~  
812 ~~supplemental funds among hospital providers, provided that when~~  
813 ~~compared to a hospital's prior year supplemental payments,~~  
814 ~~supplemental payments made pursuant to any such transitional~~  
815 ~~program shall not result in a decrease of more than five percent~~  
816 ~~(5%) and shall not increase by more than the amount needed to~~  
817 ~~maximize the distribution of the available funds.~~

818 (v) 1. To preserve and improve access to  
819 ambulance transportation provider services, the division shall





820 seek CMS approval to make ambulance service access payments as set  
821 forth in this subsection (A) (18) (b) for all covered emergency  
822 ambulance services rendered on or after July 1, 2022, and shall  
823 make such ambulance service access payments for all covered  
824 services rendered on or after the effective date of CMS approval.

825                   2. The division shall calculate the  
826 ambulance service access payment amount as the balance of the  
827 portion of the Medical Care Fund related to ambulance  
828 transportation service provider assessments plus any federal  
829 matching funds earned on the balance, up to, but not to exceed,  
830 the upper payment limit gap for all emergency ambulance service  
831 providers.

832                   3. a. Except for ambulance services  
833 exempt from the assessment provided in this paragraph (18) (b), all  
834 ambulance transportation service providers shall be eligible for  
835 ambulance service access payments each state fiscal year as set  
836 forth in this paragraph (18) (b).

837                   b. In addition to any other funds  
838 paid to ambulance transportation service providers for emergency  
839 medical services provided to Medicaid beneficiaries, each eligible  
840 ambulance transportation service provider shall receive ambulance  
841 service access payments each state fiscal year equal to the  
842 ambulance transportation service provider's upper payment limit  
843 gap. Subject to approval by the Centers for Medicare and Medicaid



844 Services, ambulance service access payments shall be made no less  
845 than on a quarterly basis.

846 c. As used in this paragraph  
847 (18) (b) (v), the term "upper payment limit gap" means the  
848 difference between the total amount that the ambulance  
849 transportation service provider received from Medicaid and the  
850 average amount that the ambulance transportation service provider  
851 would have received from commercial insurers for those services  
852 reimbursed by Medicaid.

853 4. An ambulance service access payment  
854 shall not be used to offset any other payment by the division for  
855 emergency or nonemergency services to Medicaid beneficiaries.

856 (c) (i) \* \* \* ~~Not later than December 1, 2015,~~ The  
857 division shall, subject to approval by the Centers for Medicare  
858 and Medicaid Services (CMS), establish, implement and operate a  
859 Mississippi Hospital Access Program (MHAP) for the purpose of  
860 protecting patient access to hospital care through hospital  
861 inpatient reimbursement programs provided in this section designed  
862 to maintain total hospital reimbursement for inpatient services  
863 rendered by in-state hospitals and the out-of-state hospital that  
864 is authorized by federal law to submit intergovernmental transfers  
865 (IGTs) to the State of Mississippi and is classified as Level I  
866 trauma center located in a county contiguous to the state line at  
867 the maximum levels permissible under applicable federal statutes  
868 and regulations \* \* \*, ~~at which time the current inpatient~~



869 ~~Medicare Upper Payment Limits (UPL) Program for hospital inpatient~~  
870 ~~services shall transition to the MHAP.~~

871 (ii) Subject to approval by the Centers for  
872 Medicare and Medicaid Services (CMS), the MHAP shall provide  
873 increased inpatient capitation (PMPM) payments to managed care  
874 entities contracting with the division pursuant to subsection (H)  
875 of this section to support availability of hospital services or  
876 such other payments permissible under federal law necessary to  
877 accomplish the intent of this subsection.

878 \* \* \* ~~\_\_\_\_\_ (iii) The intent of this subparagraph~~  
879 ~~(c) is that effective for all inpatient hospital Medicaid services~~  
880 ~~during state fiscal year 2016, and so long as this provision shall~~  
881 ~~remain in effect hereafter, the division shall to the fullest~~  
882 ~~extent feasible replace the additional reimbursement for hospital~~  
883 ~~inpatient services under the inpatient Medicare Upper Payment~~  
884 ~~Limits (UPL) Program with additional reimbursement under the MHAP~~  
885 ~~and other payment programs for inpatient and/or outpatient~~  
886 ~~payments which may be developed under the authority of this~~  
887 ~~paragraph.~~

888 ( \* \* \* ~~iv~~ viii) The division shall assess each  
889 hospital as provided in Section 43-13-145(4) (a) for the purpose of  
890 financing the state portion of the MHAP, supplemental payments and  
891 such other purposes as specified in Section 43-13-145. The  
892 assessment will remain in effect as long as the MHAP and  
893 supplemental payments are in effect.



894 (iv) The division shall maximize total  
895 federal funding for MHAP, UPL and other supplemental payment  
896 programs in effect for state fiscal year 2025 and shall not change  
897 the methodologies, formulas, models or preprints used to calculate  
898 the distribution of supplemental payments to hospitals from those  
899 methodologies, formulas, models or preprints in effect and as  
900 approved by the Centers for Medicare and Medicaid Services for  
901 state fiscal year 2025 as of December 31, 2024, except to update  
902 the time period to the most recent annual period or as required by  
903 federal law or regulation. The provisions of this subparagraph  
904 (iv) do not apply if the hospital is no longer eligible to  
905 participate in the supplemental payment program pursuant to  
906 federal or state law or if a hospital that was not included in the  
907 distribution is subsequently opened or closed. Nothing in this  
908 subparagraph (iv) shall be construed to prohibit an aggregate  
909 increase or decrease in total funding to maximize the total  
910 funding available for hospital supplemental payment programs so  
911 long as the increased funding is distributed pursuant to the state  
912 fiscal year 2025 methodologies, formulas, models or preprints.  
913 Notwithstanding the above, the division shall conform the penalty  
914 for failure to satisfy quality standards to an amount that is more  
915 comparable to the value of the encounter.

916 (19) (a) Perinatal risk management services. The  
917 division shall promulgate regulations to be effective from and  
918 after October 1, 1988, to establish a comprehensive perinatal



919 system for risk assessment of all pregnant and infant Medicaid  
920 recipients and for management, education and follow-up for those  
921 who are determined to be at risk. Services to be performed  
922 include case management, nutrition assessment/counseling,  
923 psychosocial assessment/counseling and health education. The  
924 division \* \* \*~~shall~~ may contract with the State Department of  
925 Health to provide services within this paragraph (Perinatal High  
926 Risk Management/Infant Services System (PHRM/ISS)) for any  
927 eligible beneficiary that cannot receive these services under a  
928 different program. The State Department of Health shall be  
929 reimbursed on a full reasonable cost basis for services provided  
930 under this subparagraph (a). Any program authorized under  
931 subsection (H) of this section shall develop a perinatal risk  
932 management services program in consultation with the division and  
933 the State Department of Health or shall contract with the State  
934 Department of Health for these services, and the programs shall  
935 begin providing these services no later than January 1, 2026.

936 (b) Early intervention system services. The  
937 division shall cooperate with the State Department of Health,  
938 acting as lead agency, in the development and implementation of a  
939 statewide system of delivery of early intervention services, under  
940 Part C of the Individuals with Disabilities Education Act (IDEA).  
941 The State Department of Health shall certify annually in writing  
942 to the executive director of the division the dollar amount of  
943 state early intervention funds available that will be utilized as



944 a certified match for Medicaid matching funds. Those funds then  
945 shall be used to provide expanded targeted case management  
946 services for Medicaid eligible children with special needs who are  
947 eligible for the state's early intervention system.

948 Qualifications for persons providing service coordination shall be  
949 determined by the State Department of Health and the Division of  
950 Medicaid.

951 (20) Home- and community-based services for physically  
952 disabled approved services as allowed by a waiver from the United  
953 States Department of Health and Human Services for home- and  
954 community-based services for physically disabled people using  
955 state funds that are provided from the appropriation to the State  
956 Department of Rehabilitation Services and used to match federal  
957 funds under a cooperative agreement between the division and the  
958 department, provided that funds for these services are  
959 specifically appropriated to the Department of Rehabilitation  
960 Services.

961 (21) Nurse practitioner services. Services furnished  
962 by a registered nurse who is licensed and certified by the  
963 Mississippi Board of Nursing as a nurse practitioner, including,  
964 but not limited to, nurse anesthetists, nurse midwives, family  
965 nurse practitioners, family planning nurse practitioners,  
966 pediatric nurse practitioners, obstetrics-gynecology nurse  
967 practitioners and neonatal nurse practitioners, under regulations  
968 adopted by the division. Reimbursement for those services shall



969 not exceed ninety percent (90%) of the reimbursement rate for  
970 comparable services rendered by a physician. The division may  
971 provide for a reimbursement rate for nurse practitioner services  
972 of up to one hundred percent (100%) of the reimbursement rate for  
973 comparable services rendered by a physician for nurse practitioner  
974 services that are provided after the normal working hours of the  
975 nurse practitioner, as determined in accordance with regulations  
976 of the division.

977           (22) Ambulatory services delivered in federally  
978 qualified health centers, rural health centers and clinics of the  
979 local health departments of the State Department of Health for  
980 individuals eligible for Medicaid under this article based on  
981 reasonable costs as determined by the division. Federally  
982 qualified health centers shall be reimbursed by the Medicaid  
983 prospective payment system as approved by the Centers for Medicare  
984 and Medicaid Services. The division shall recognize federally  
985 qualified health centers (FQHCs), rural health clinics (RHCs) and  
986 community mental health centers (CMHCs) as both an originating and  
987 distant site provider for the purposes of telehealth  
988 reimbursement. The division is further authorized and directed to  
989 reimburse FQHCs, RHCs and CMHCs for both distant site and  
990 originating site services when such services are appropriately  
991 provided by the same organization.

992           (23) Inpatient psychiatric services.



993 (a) Inpatient psychiatric services to be  
994 determined by the division for recipients under age twenty-one  
995 (21) that are provided under the direction of a physician in an  
996 inpatient program in a licensed acute care psychiatric facility or  
997 in a licensed psychiatric residential treatment facility, before  
998 the recipient reaches age twenty-one (21) or, if the recipient was  
999 receiving the services immediately before he or she reached age  
1000 twenty-one (21), before the earlier of the date he or she no  
1001 longer requires the services or the date he or she reaches age  
1002 twenty-two (22), as provided by federal regulations. From and  
1003 after January 1, 2015, the division shall update the fair rental  
1004 reimbursement system for psychiatric residential treatment  
1005 facilities. Precertification of inpatient days and residential  
1006 treatment days must be obtained as required by the division. From  
1007 and after July 1, 2009, all state-owned and state-operated  
1008 facilities that provide inpatient psychiatric services to persons  
1009 under age twenty-one (21) who are eligible for Medicaid  
1010 reimbursement shall be reimbursed for those services on a full  
1011 reasonable cost basis.

1012 (b) The division may reimburse for services  
1013 provided by a licensed freestanding psychiatric hospital to  
1014 Medicaid recipients over the age of twenty-one (21) in a method  
1015 and manner consistent with the provisions of Section 43-13-117.5.

1016 (24) [Deleted]

1017 (25) [Deleted]





1018           (26) Hospice care. As used in this paragraph, the term  
1019 "hospice care" means a coordinated program of active professional  
1020 medical attention within the home and outpatient and inpatient  
1021 care that treats the terminally ill patient and family as a unit,  
1022 employing a medically directed interdisciplinary team. The  
1023 program provides relief of severe pain or other physical symptoms  
1024 and supportive care to meet the special needs arising out of  
1025 physical, psychological, spiritual, social and economic stresses  
1026 that are experienced during the final stages of illness and during  
1027 dying and bereavement and meets the Medicare requirements for  
1028 participation as a hospice as provided in federal regulations.

1029           (27) Group health plan premiums and cost-sharing if it  
1030 is cost-effective as defined by the United States Secretary of  
1031 Health and Human Services.

1032           (28) Other health insurance premiums that are  
1033 cost-effective as defined by the United States Secretary of Health  
1034 and Human Services. Medicare eligible must have Medicare Part B  
1035 before other insurance premiums can be paid.

1036           (29) The Division of Medicaid may apply for a waiver  
1037 from the United States Department of Health and Human Services for  
1038 home- and community-based services for developmentally disabled  
1039 people using state funds that are provided from the appropriation  
1040 to the State Department of Mental Health and/or funds transferred  
1041 to the department by a political subdivision or instrumentality of  
1042 the state and used to match federal funds under a cooperative



1043 agreement between the division and the department, provided that  
1044 funds for these services are specifically appropriated to the  
1045 Department of Mental Health and/or transferred to the department  
1046 by a political subdivision or instrumentality of the state.

1047 (30) Pediatric skilled nursing services as determined  
1048 by the division and in a manner consistent with regulations  
1049 promulgated by the Mississippi State Department of Health.

1050 (31) Targeted case management services for children  
1051 with special needs, under waivers from the United States  
1052 Department of Health and Human Services, using state funds that  
1053 are provided from the appropriation to the Mississippi Department  
1054 of Human Services and used to match federal funds under a  
1055 cooperative agreement between the division and the department.

1056 (32) Care and services provided in Christian Science  
1057 Sanatoria listed and certified by the Commission for Accreditation  
1058 of Christian Science Nursing Organizations/Facilities, Inc.,  
1059 rendered in connection with treatment by prayer or spiritual means  
1060 to the extent that those services are subject to reimbursement  
1061 under Section 1903 of the federal Social Security Act.

1062 (33) Podiatrist services.

1063 (34) Assisted living services as provided through  
1064 home- and community-based services under Title XIX of the federal  
1065 Social Security Act, as amended, subject to the availability of  
1066 funds specifically appropriated for that purpose by the  
1067 Legislature.



1068           (35) Services and activities authorized in Sections  
1069 43-27-101 and 43-27-103, using state funds that are provided from  
1070 the appropriation to the Mississippi Department of Human Services  
1071 and used to match federal funds under a cooperative agreement  
1072 between the division and the department.

1073           (36) Nonemergency transportation services for  
1074 Medicaid-eligible persons as determined by the division. The PEER  
1075 Committee shall conduct a performance evaluation of the  
1076 nonemergency transportation program to evaluate the administration  
1077 of the program and the providers of transportation services to  
1078 determine the most cost-effective ways of providing nonemergency  
1079 transportation services to the patients served under the program.  
1080 The performance evaluation shall be completed and provided to the  
1081 members of the Senate Medicaid Committee and the House Medicaid  
1082 Committee not later than January 1, 2019, and every two (2) years  
1083 thereafter.

1084           (37) [Deleted]

1085           (38) Chiropractic services. A chiropractor's manual  
1086 manipulation of the spine to correct a subluxation, if x-ray  
1087 demonstrates that a subluxation exists and if the subluxation has  
1088 resulted in a neuromusculoskeletal condition for which  
1089 manipulation is appropriate treatment, and related spinal x-rays  
1090 performed to document these conditions. Reimbursement for  
1091 chiropractic services shall not exceed Seven Hundred Dollars  
1092 (\$700.00) per year per beneficiary.



1093 (39) Dually eligible Medicare/Medicaid beneficiaries.  
1094 The division shall pay the Medicare deductible and coinsurance  
1095 amounts for services available under Medicare, as determined by  
1096 the division. From and after July 1, 2009, the division shall  
1097 reimburse crossover claims for inpatient hospital services and  
1098 crossover claims covered under Medicare Part B in the same manner  
1099 that was in effect on January 1, 2008, unless specifically  
1100 authorized by the Legislature to change this method.

1101 (40) [Deleted]

1102 (41) Services provided by the State Department of  
1103 Rehabilitation Services for the care and rehabilitation of persons  
1104 with spinal cord injuries or traumatic brain injuries, as allowed  
1105 under waivers from the United States Department of Health and  
1106 Human Services, using up to seventy-five percent (75%) of the  
1107 funds that are appropriated to the Department of Rehabilitation  
1108 Services from the Spinal Cord and Head Injury Trust Fund  
1109 established under Section 37-33-261 and used to match federal  
1110 funds under a cooperative agreement between the division and the  
1111 department.

1112 (42) [Deleted]

1113 (43) The division shall provide reimbursement,  
1114 according to a payment schedule developed by the division, for  
1115 smoking cessation medications for pregnant women during their  
1116 pregnancy and other Medicaid-eligible women who are of  
1117 child-bearing age.



1118 (44) Nursing facility services for the severely  
1119 disabled.

1120 (a) Severe disabilities include, but are not  
1121 limited to, spinal cord injuries, closed-head injuries and  
1122 ventilator-dependent patients.

1123 (b) Those services must be provided in a long-term  
1124 care nursing facility dedicated to the care and treatment of  
1125 persons with severe disabilities.

1126 (45) Physician assistant services. Services furnished  
1127 by a physician assistant who is licensed by the State Board of  
1128 Medical Licensure and is practicing with physician supervision  
1129 under regulations adopted by the board, under regulations adopted  
1130 by the division. Reimbursement for those services shall not  
1131 exceed ninety percent (90%) of the reimbursement rate for  
1132 comparable services rendered by a physician. The division may  
1133 provide for a reimbursement rate for physician assistant services  
1134 of up to one hundred percent (100%) or the reimbursement rate for  
1135 comparable services rendered by a physician for physician  
1136 assistant services that are provided after the normal working  
1137 hours of the physician assistant, as determined in accordance with  
1138 regulations of the division.

1139 (46) The division shall make application to the federal  
1140 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
1141 develop and provide services for children with serious emotional  
1142 disturbances as defined in Section 43-14-1(1), which may include



1143 home- and community-based services, case management services or  
1144 managed care services through mental health providers certified by  
1145 the Department of Mental Health. The division may implement and  
1146 provide services under this waived program only if funds for  
1147 these services are specifically appropriated for this purpose by  
1148 the Legislature, or if funds are voluntarily provided by affected  
1149 agencies.

1150           (47) (a) The division may develop and implement  
1151 disease management programs for individuals with high-cost chronic  
1152 diseases and conditions, including the use of grants, waivers,  
1153 demonstrations or other projects as necessary.

1154           (b) Participation in any disease management  
1155 program implemented under this paragraph (47) is optional with the  
1156 individual. An individual must affirmatively elect to participate  
1157 in the disease management program in order to participate, and may  
1158 elect to discontinue participation in the program at any time.

1159           (48) Pediatric long-term acute care hospital services.

1160           (a) Pediatric long-term acute care hospital  
1161 services means services provided to eligible persons under  
1162 twenty-one (21) years of age by a freestanding Medicare-certified  
1163 hospital that has an average length of inpatient stay greater than  
1164 twenty-five (25) days and that is primarily engaged in providing  
1165 chronic or long-term medical care to persons under twenty-one (21)  
1166 years of age.



1167 (b) The services under this paragraph (48) shall  
1168 be reimbursed as a separate category of hospital services.

1169 (49) The division may establish copayments and/or  
1170 coinsurance for any Medicaid services for which copayments and/or  
1171 coinsurance are allowable under federal law or regulation.

1172 (50) Services provided by the State Department of  
1173 Rehabilitation Services for the care and rehabilitation of persons  
1174 who are deaf and blind, as allowed under waivers from the United  
1175 States Department of Health and Human Services to provide home-  
1176 and community-based services using state funds that are provided  
1177 from the appropriation to the State Department of Rehabilitation  
1178 Services or if funds are voluntarily provided by another agency.

1179 (51) Upon determination of Medicaid eligibility and in  
1180 association with annual redetermination of Medicaid eligibility,  
1181 beneficiaries shall be encouraged to undertake a physical  
1182 examination that will establish a base-line level of health and  
1183 identification of a usual and customary source of care (a medical  
1184 home) to aid utilization of disease management tools. This  
1185 physical examination and utilization of these disease management  
1186 tools shall be consistent with current United States Preventive  
1187 Services Task Force or other recognized authority recommendations.

1188 For persons who are determined ineligible for Medicaid, the  
1189 division will provide information and direction for accessing  
1190 medical care and services in the area of their residence.



1191           (52) Notwithstanding any provisions of this article,  
1192 the division may pay enhanced reimbursement fees related to trauma  
1193 care, as determined by the division in conjunction with the State  
1194 Department of Health, using funds appropriated to the State  
1195 Department of Health for trauma care and services and used to  
1196 match federal funds under a cooperative agreement between the  
1197 division and the State Department of Health. The division, in  
1198 conjunction with the State Department of Health, may use grants,  
1199 waivers, demonstrations, enhanced reimbursements, Upper Payment  
1200 Limits Programs, supplemental payments, or other projects as  
1201 necessary in the development and implementation of this  
1202 reimbursement program.

1203           (53) Targeted case management services for high-cost  
1204 beneficiaries may be developed by the division for all services  
1205 under this section.

1206           (54) [Deleted]

1207           (55) Therapy services. The plan of care for therapy  
1208 services may be developed to cover a period of treatment for up to  
1209 six (6) months, but in no event shall the plan of care exceed a  
1210 six-month period of treatment. The projected period of treatment  
1211 must be indicated on the initial plan of care and must be updated  
1212 with each subsequent revised plan of care. Based on medical  
1213 necessity, the division shall approve certification periods for  
1214 less than or up to six (6) months, but in no event shall the  
1215 certification period exceed the period of treatment indicated on





1216 the plan of care. The appeal process for any reduction in therapy  
1217 services shall be consistent with the appeal process in federal  
1218 regulations.

1219 (56) Prescribed pediatric extended care centers  
1220 services for medically dependent or technologically dependent  
1221 children with complex medical conditions that require continual  
1222 care as prescribed by the child's attending physician, as  
1223 determined by the division.

1224 (57) No Medicaid benefit shall restrict coverage for  
1225 medically appropriate treatment prescribed by a physician and  
1226 agreed to by a fully informed individual, or if the individual  
1227 lacks legal capacity to consent by a person who has legal  
1228 authority to consent on his or her behalf, based on an  
1229 individual's diagnosis with a terminal condition. As used in this  
1230 paragraph (57), "terminal condition" means any aggressive  
1231 malignancy, chronic end-stage cardiovascular or cerebral vascular  
1232 disease, or any other disease, illness or condition which a  
1233 physician diagnoses as terminal.

1234 (58) Treatment services for persons with opioid  
1235 dependency or other highly addictive substance use disorders. The  
1236 division is authorized to reimburse eligible providers for  
1237 treatment of opioid dependency and other highly addictive  
1238 substance use disorders, as determined by the division. Treatment  
1239 related to these conditions shall not count against any physician  
1240 visit limit imposed under this section.



1241           (59) The division shall allow beneficiaries between the  
1242 ages of ten (10) and eighteen (18) years to receive vaccines  
1243 through a pharmacy venue. The division and the State Department  
1244 of Health shall coordinate and notify OB-GYN providers that the  
1245 Vaccines for Children program is available to providers free of  
1246 charge.

1247           (60) Border city university-affiliated pediatric  
1248 teaching hospital.

1249           (a) Payments may only be made to a border city  
1250 university-affiliated pediatric teaching hospital if the Centers  
1251 for Medicare and Medicaid Services (CMS) approve an increase in  
1252 the annual request for the provider payment initiative authorized  
1253 under 42 CFR Section 438.6(c) in an amount equal to or greater  
1254 than the estimated annual payment to be made to the border city  
1255 university-affiliated pediatric teaching hospital. The estimate  
1256 shall be based on the hospital's prior year Mississippi managed  
1257 care utilization.

1258           (b) As used in this paragraph (60), the term  
1259 "border city university-affiliated pediatric teaching hospital"  
1260 means an out-of-state hospital located within a city bordering the  
1261 eastern bank of the Mississippi River and the State of Mississippi  
1262 that submits to the division a copy of a current and effective  
1263 affiliation agreement with an accredited university and other  
1264 documentation establishing that the hospital is  
1265 university-affiliated, is licensed and designated as a pediatric



1266 hospital or pediatric primary hospital within its home state,  
1267 maintains at least five (5) different pediatric specialty training  
1268 programs, and maintains at least one hundred (100) operated beds  
1269 dedicated exclusively for the treatment of patients under the age  
1270 of twenty-one (21) years.

1271 (c) The ~~\*\*\*cost of~~ payment for providing services  
1272 to Mississippi Medicaid beneficiaries under the age of twenty-one  
1273 (21) years who are treated by a border city university-affiliated  
1274 pediatric teaching hospital shall not exceed the Medicaid payment  
1275 to Medicaid cost ratio of providing ~~\*\*\*the same~~ services to  
1276 Medicaid individuals \*\*\*in hospitals by a university-affiliated  
1277 pedsiatric teaching hospital in ~~\*\*\*the state~~ Mississippi.

1278 (d) It is the intent of the Legislature that  
1279 payments shall not result in any in-state hospital receiving  
1280 payments lower than they would otherwise receive if not for the  
1281 payments made to any border city university-affiliated pediatric  
1282 teaching hospital.

1283 (e) This paragraph (60) shall stand repealed on  
1284 July 1, ~~\*\*\*2024~~ 2027.

1285 (B) Planning and development districts participating in the  
1286 home- and community-based services program for the elderly and  
1287 disabled as case management providers shall be reimbursed for case  
1288 management services at the maximum rate approved by the Centers  
1289 for Medicare and Medicaid Services (CMS).



1290 (C) The division may pay to those providers who participate  
1291 in and accept patient referrals from the division's emergency room  
1292 redirection program a percentage, as determined by the division,  
1293 of savings achieved according to the performance measures and  
1294 reduction of costs required of that program. Federally qualified  
1295 health centers may participate in the emergency room redirection  
1296 program, and the division may pay those centers a percentage of  
1297 any savings to the Medicaid program achieved by the centers'  
1298 accepting patient referrals through the program, as provided in  
1299 this subsection (C).

1300 (D) (1) As used in this subsection (D), the following terms  
1301 shall be defined as provided in this paragraph, except as  
1302 otherwise provided in this subsection:

1303 (a) "Committees" means the Medicaid Committees of  
1304 the House of Representatives and the Senate, and "committee" means  
1305 either one of those committees.

1306 (b) "Rate change" means an increase, decrease or  
1307 other change in the payments or rates of reimbursement, or a  
1308 change in any payment methodology that results in an increase,  
1309 decrease or other change in the payments or rates of  
1310 reimbursement, to any Medicaid provider that renders any services  
1311 authorized to be provided to Medicaid recipients under this  
1312 article.

1313 (2) Whenever the Division of Medicaid proposes a rate  
1314 change, the division shall give notice to the chairmen of the



1315 committees at least thirty (30) calendar days, when possible,  
1316 before the proposed rate change is scheduled to take effect. If  
1317 the division needs to expedite the thirty-day notice, the division  
1318 will notify both chairmen of that fact as soon as possible. The  
1319 division shall furnish the chairmen with a concise summary of each  
1320 proposed rate change along with the notice, and shall furnish the  
1321 chairmen with a copy of any proposed rate change upon request.  
1322 The division also shall provide a summary and copy of any proposed  
1323 rate change to any other member of the Legislature upon request.

1324 (3) If the chairman of either committee or both  
1325 chairmen jointly object to the proposed rate change or any part  
1326 thereof, the chairman or chairmen shall notify the division and  
1327 provide the reasons for their objection in writing not later than  
1328 seven (7) calendar days after receipt of the notice from the  
1329 division. The chairman or chairmen may make written  
1330 recommendations to the division for changes to be made to a  
1331 proposed rate change.

1332 (4) (a) The chairman of either committee or both  
1333 chairmen jointly may hold a committee meeting to review a proposed  
1334 rate change. If either chairman or both chairmen decide to hold a  
1335 meeting, they shall notify the division of their intention in  
1336 writing within seven (7) calendar days after receipt of the notice  
1337 from the division, and shall set the date and time for the meeting  
1338 in their notice to the division, which shall not be later than



1339 fourteen (14) calendar days after receipt of the notice from the  
1340 division.

1341 (b) After the committee meeting, the committee or  
1342 committees may object to the proposed rate change or any part  
1343 thereof. The committee or committees shall notify the division  
1344 and the reasons for their objection in writing not later than  
1345 seven (7) calendar days after the meeting. The committee or  
1346 committees may make written recommendations to the division for  
1347 changes to be made to a proposed rate change.

1348 (5) If both chairmen notify the division in writing  
1349 within seven (7) calendar days after receipt of the notice from  
1350 the division that they do not object to the proposed rate change  
1351 and will not be holding a meeting to review the proposed rate  
1352 change, the proposed rate change will take effect on the original  
1353 date as scheduled by the division or on such other date as  
1354 specified by the division.

1355 (6) (a) If there are any objections to a proposed rate  
1356 change or any part thereof from either or both of the chairmen or  
1357 the committees, the division may withdraw the proposed rate  
1358 change, make any of the recommended changes to the proposed rate  
1359 change, or not make any changes to the proposed rate change.

1360 (b) If the division does not make any changes to  
1361 the proposed rate change, it shall notify the chairmen of that  
1362 fact in writing, and the proposed rate change shall take effect on



1363 the original date as scheduled by the division or on such other  
1364 date as specified by the division.

1365 (c) If the division makes any changes to the  
1366 proposed rate change, the division shall notify the chairmen of  
1367 its actions in writing, and the revised proposed rate change shall  
1368 take effect on the date as specified by the division.

1369 (7) Nothing in this subsection (D) shall be construed  
1370 as giving the chairmen or the committees any authority to veto,  
1371 nullify or revise any rate change proposed by the division. The  
1372 authority of the chairmen or the committees under this subsection  
1373 shall be limited to reviewing, making objections to and making  
1374 recommendations for changes to rate changes proposed by the  
1375 division.

1376 (E) Notwithstanding any provision of this article, no new  
1377 groups or categories of recipients and new types of care and  
1378 services may be added without enabling legislation from the  
1379 Mississippi Legislature, except that the division may authorize  
1380 those changes without enabling legislation when the addition of  
1381 recipients or services is ordered by a court of proper authority.

1382 (F) The executive director shall keep the Governor advised  
1383 on a timely basis of the funds available for expenditure and the  
1384 projected expenditures. Notwithstanding any other provisions of  
1385 this article, if current or projected expenditures of the division  
1386 are reasonably anticipated to exceed the amount of funds  
1387 appropriated to the division for any fiscal year, the Governor,



1388 after consultation with the executive director, shall take all  
1389 appropriate measures to reduce costs, which may include, but are  
1390 not limited to:

1391 (1) Reducing or discontinuing any or all services that  
1392 are deemed to be optional under Title XIX of the Social Security  
1393 Act;

1394 (2) Reducing reimbursement rates for any or all service  
1395 types;

1396 (3) Imposing additional assessments on health care  
1397 providers; or

1398 (4) Any additional cost-containment measures deemed  
1399 appropriate by the Governor.

1400 To the extent allowed under federal law, any reduction to  
1401 services or reimbursement rates under this subsection (F) shall be  
1402 accompanied by a reduction, to the fullest allowable amount, to  
1403 the profit margin and administrative fee portions of capitated  
1404 payments to organizations described in paragraph (1) of subsection  
1405 (H).

1406 Beginning in fiscal year 2010 and in fiscal years thereafter,  
1407 when Medicaid expenditures are projected to exceed funds available  
1408 for the fiscal year, the division shall submit the expected  
1409 shortfall information to the PEER Committee not later than  
1410 December 1 of the year in which the shortfall is projected to  
1411 occur. PEER shall review the computations of the division and





1412 report its findings to the Legislative Budget Office not later  
1413 than January 7 in any year.

1414 (G) Notwithstanding any other provision of this article, it  
1415 shall be the duty of each provider participating in the Medicaid  
1416 program to keep and maintain books, documents and other records as  
1417 prescribed by the Division of Medicaid in accordance with federal  
1418 laws and regulations.

1419 (H) (1) Notwithstanding any other provision of this  
1420 article, the division is authorized to implement (a) a managed  
1421 care program, (b) a coordinated care program, (c) a coordinated  
1422 care organization program, (d) a health maintenance organization  
1423 program, (e) a patient-centered medical home program, (f) an  
1424 accountable care organization program, (g) provider-sponsored  
1425 health plan, or (h) any combination of the above programs. As a  
1426 condition for the approval of any program under this subsection  
1427 (H) (1), the division shall require that no managed care program,  
1428 coordinated care program, coordinated care organization program,  
1429 health maintenance organization program, or provider-sponsored  
1430 health plan may:

1431 (a) Pay providers at a rate that is less than the  
1432 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)  
1433 reimbursement rate;

1434 (b) Override the medical decisions of hospital  
1435 physicians or staff regarding patients admitted to a hospital for  
1436 an emergency medical condition as defined by 42 US Code Section



1437 1395dd. This restriction (b) does not prohibit the retrospective  
1438 review of the appropriateness of the determination that an  
1439 emergency medical condition exists by chart review or coding  
1440 algorithm, nor does it prohibit prior authorization for  
1441 nonemergency hospital admissions;

1442 (c) Pay providers at a rate that is less than the  
1443 normal Medicaid reimbursement rate. It is the intent of the  
1444 Legislature that all managed care entities described in this  
1445 subsection (H), in collaboration with the division, develop and  
1446 implement innovative payment models that incentivize improvements  
1447 in health care quality, outcomes, or value, as determined by the  
1448 division. Participation in the provider network of any managed  
1449 care, coordinated care, provider-sponsored health plan, or similar  
1450 contractor shall not be conditioned on the provider's agreement to  
1451 accept such alternative payment models;

1452 (d) Implement a prior authorization and  
1453 utilization review program for medical services, transportation  
1454 services and prescription drugs that is more stringent than the  
1455 prior authorization processes used by the division in its  
1456 administration of the Medicaid program. Not later than December  
1457 2, 2021, the contractors that are receiving capitated payments  
1458 under a managed care delivery system established under this  
1459 subsection (H) shall submit a report to the Chairmen of the House  
1460 and Senate Medicaid Committees on the status of the prior  
1461 authorization and utilization review program for medical services,



1462 transportation services and prescription drugs that is required to  
1463 be implemented under this subparagraph (d);

1464 (e) [Deleted]

1465 (f) Implement a preferred drug list that is more  
1466 stringent than the mandatory preferred drug list established by  
1467 the division under subsection (A)(9) of this section;

1468 (g) Implement a policy which denies beneficiaries  
1469 with hemophilia access to the federally funded hemophilia  
1470 treatment centers as part of the Medicaid Managed Care network of  
1471 providers.

1472 Each health maintenance organization, coordinated care  
1473 organization, provider-sponsored health plan, or other  
1474 organization paid for services on a capitated basis by the  
1475 division under any managed care program or coordinated care  
1476 program implemented by the division under this section shall use a  
1477 clear set of level of care guidelines in the determination of  
1478 medical necessity and in all utilization management practices,  
1479 including the prior authorization process, concurrent reviews,  
1480 retrospective reviews and payments, that are consistent with  
1481 widely accepted professional standards of care. Organizations  
1482 participating in a managed care program or coordinated care  
1483 program implemented by the division may not use any additional  
1484 criteria that would result in denial of care that would be  
1485 determined appropriate and, therefore, medically necessary under  
1486 those levels of care guidelines.



1487           (2) Notwithstanding any provision of this section, the  
1488 recipients eligible for enrollment into a Medicaid Managed Care  
1489 Program authorized under this subsection (H) may include only  
1490 those categories of recipients eligible for participation in the  
1491 Medicaid Managed Care Program as of January 1, 2021, the  
1492 Children's Health Insurance Program (CHIP), and the CMS-approved  
1493 Section 1115 demonstration waivers in operation as of January 1,  
1494 2021. No expansion of Medicaid Managed Care Program contracts may  
1495 be implemented by the division without enabling legislation from  
1496 the Mississippi Legislature.

1497           (3) (a) Any contractors receiving capitated payments  
1498 under a managed care delivery system established in this section  
1499 shall provide to the Legislature and the division statistical data  
1500 to be shared with provider groups in order to improve patient  
1501 access, appropriate utilization, cost savings and health outcomes  
1502 not later than October 1 of each year. Additionally, each  
1503 contractor shall disclose to the Chairmen of the Senate and House  
1504 Medicaid Committees the administrative expenses costs for the  
1505 prior calendar year, and the number of full-equivalent employees  
1506 located in the State of Mississippi dedicated to the Medicaid and  
1507 CHIP lines of business as of June 30 of the current year.

1508           (b) The division and the contractors participating  
1509 in the managed care program, a coordinated care program or a  
1510 provider-sponsored health plan shall be subject to annual program  
1511 reviews or audits performed by the Office of the State Auditor,



1512 the PEER Committee, the Department of Insurance and/or independent  
1513 third parties.

1514 (c) Those reviews shall include, but not be  
1515 limited to, at least two (2) of the following items:

1516 (i) The financial benefit to the State of  
1517 Mississippi of the managed care program,

1518 (ii) The difference between the premiums paid  
1519 to the managed care contractors and the payments made by those  
1520 contractors to health care providers,

1521 (iii) Compliance with performance measures  
1522 required under the contracts,

1523 (iv) Administrative expense allocation  
1524 methodologies,

1525 (v) Whether nonprovider payments assigned as  
1526 medical expenses are appropriate,

1527 (vi) Capitated arrangements with related  
1528 party subcontractors,

1529 (vii) Reasonableness of corporate  
1530 allocations,

1531 (viii) Value-added benefits and the extent to  
1532 which they are used,

1533 (ix) The effectiveness of subcontractor  
1534 oversight, including subcontractor review,

1535 (x) Whether health care outcomes have been  
1536 improved, and



1537 (xi) The most common claim denial codes to  
1538 determine the reasons for the denials.

1539 The audit reports shall be considered public documents and  
1540 shall be posted in their entirety on the division's website.

1541 (4) All health maintenance organizations, coordinated  
1542 care organizations, provider-sponsored health plans, or other  
1543 organizations paid for services on a capitated basis by the  
1544 division under any managed care program or coordinated care  
1545 program implemented by the division under this section shall  
1546 reimburse all providers in those organizations at rates no lower  
1547 than those provided under this section for beneficiaries who are  
1548 not participating in those programs.

1549 (5) No health maintenance organization, coordinated  
1550 care organization, provider-sponsored health plan, or other  
1551 organization paid for services on a capitated basis by the  
1552 division under any managed care program or coordinated care  
1553 program implemented by the division under this section shall  
1554 require its providers or beneficiaries to use any pharmacy that  
1555 ships, mails or delivers prescription drugs or legend drugs or  
1556 devices.

1557 (6) (a) Not later than December 1, 2021, the  
1558 contractors who are receiving capitated payments under a managed  
1559 care delivery system established under this subsection (H) shall  
1560 develop and implement a uniform credentialing process for  
1561 providers. Under that uniform credentialing process, a provider



1562 who meets the criteria for credentialing will be credentialed with  
1563 all of those contractors and no such provider will have to be  
1564 separately credentialed by any individual contractor in order to  
1565 receive reimbursement from the contractor. Not later than  
1566 December 2, 2021, those contractors shall submit a report to the  
1567 Chairmen of the House and Senate Medicaid Committees on the status  
1568 of the uniform credentialing process for providers that is  
1569 required under this subparagraph (a).

1570 (b) If those contractors have not implemented a  
1571 uniform credentialing process as described in subparagraph (a) by  
1572 December 1, 2021, the division shall develop and implement, not  
1573 later than July 1, 2022, a single, consolidated credentialing  
1574 process by which all providers will be credentialed. Under the  
1575 division's single, consolidated credentialing process, no such  
1576 contractor shall require its providers to be separately  
1577 credentialed by the contractor in order to receive reimbursement  
1578 from the contractor, but those contractors shall recognize the  
1579 credentialing of the providers by the division's credentialing  
1580 process.

1581 (c) The division shall require a uniform provider  
1582 credentialing application that shall be used in the credentialing  
1583 process that is established under subparagraph (a) or (b). If the  
1584 contractor or division, as applicable, has not approved or denied  
1585 the provider credentialing application within sixty (60) days of  
1586 receipt of the completed application that includes all required



1587 information necessary for credentialing, then the contractor or  
1588 division, upon receipt of a written request from the applicant and  
1589 within five (5) business days of its receipt, shall issue a  
1590 temporary provider credential/enrollment to the applicant if the  
1591 applicant has a valid Mississippi professional or occupational  
1592 license to provide the health care services to which the  
1593 credential/enrollment would apply. The contractor or the division  
1594 shall not issue a temporary credential/enrollment if the applicant  
1595 has reported on the application a history of medical or other  
1596 professional or occupational malpractice claims, a history of  
1597 substance abuse or mental health issues, a criminal record, or a  
1598 history of medical or other licensing board, state or federal  
1599 disciplinary action, including any suspension from participation  
1600 in a federal or state program. The temporary  
1601 credential/enrollment shall be effective upon issuance and shall  
1602 remain in effect until the provider's credentialing/enrollment  
1603 application is approved or denied by the contractor or division.  
1604 The contractor or division shall render a final decision regarding  
1605 credentialing/enrollment of the provider within sixty (60) days  
1606 from the date that the temporary provider credential/enrollment is  
1607 issued to the applicant.

1608 (d) If the contractor or division does not render  
1609 a final decision regarding credentialing/enrollment of the  
1610 provider within the time required in subparagraph (c), the  
1611 provider shall be deemed to be credentialed by and enrolled with





1612 all of the contractors and eligible to receive reimbursement from  
1613 the contractors.

1614 (7) (a) Each contractor that is receiving capitated  
1615 payments under a managed care delivery system established under  
1616 this subsection (H) shall provide to each provider for whom the  
1617 contractor has denied the coverage of a procedure that was ordered  
1618 or requested by the provider for or on behalf of a patient, a  
1619 letter that provides a detailed explanation of the reasons for the  
1620 denial of coverage of the procedure and the name and the  
1621 credentials of the person who denied the coverage. The letter  
1622 shall be sent to the provider in electronic format.

1623 (b) After a contractor that is receiving capitated  
1624 payments under a managed care delivery system established under  
1625 this subsection (H) has denied coverage for a claim submitted by a  
1626 provider, the contractor shall issue to the provider within sixty  
1627 (60) days a final ruling of denial of the claim that allows the  
1628 provider to have a state fair hearing and/or agency appeal with  
1629 the division. If a contractor does not issue a final ruling of  
1630 denial within sixty (60) days as required by this subparagraph  
1631 (b), the provider's claim shall be deemed to be automatically  
1632 approved and the contractor shall pay the amount of the claim to  
1633 the provider.

1634 (c) After a contractor has issued a final ruling  
1635 of denial of a claim submitted by a provider, the division shall  
1636 conduct a state fair hearing and/or agency appeal on the matter of



1637 the disputed claim between the contractor and the provider within  
1638 sixty (60) days, and shall render a decision on the matter within  
1639 thirty (30) days after the date of the hearing and/or appeal.

1640 (8) It is the intention of the Legislature that the  
1641 division evaluate the feasibility of using a single vendor to  
1642 administer pharmacy benefits provided under a managed care  
1643 delivery system established under this subsection (H). Providers  
1644 of pharmacy benefits shall cooperate with the division in any  
1645 transition to a carve-out of pharmacy benefits under managed care.

1646 (9) The division shall evaluate the feasibility of  
1647 using a single vendor to administer dental benefits provided under  
1648 a managed care delivery system established in this subsection (H).  
1649 Providers of dental benefits shall cooperate with the division in  
1650 any transition to a carve-out of dental benefits under managed  
1651 care.

1652 (10) It is the intent of the Legislature that any  
1653 contractor receiving capitated payments under a managed care  
1654 delivery system established in this section shall implement  
1655 innovative programs to improve the health and well-being of  
1656 members diagnosed with prediabetes and diabetes.

1657 (11) It is the intent of the Legislature that any  
1658 contractors receiving capitated payments under a managed care  
1659 delivery system established under this subsection (H) shall work  
1660 with providers of Medicaid services to improve the utilization of  
1661 long-acting reversible contraceptives (LARCs). Not later than



1662 December 1, 2021, any contractors receiving capitated payments  
1663 under a managed care delivery system established under this  
1664 subsection (H) shall provide to the Chairmen of the House and  
1665 Senate Medicaid Committees and House and Senate Public Health  
1666 Committees a report of LARC utilization for State Fiscal Years  
1667 2018 through 2020 as well as any programs, initiatives, or efforts  
1668 made by the contractors and providers to increase LARC  
1669 utilization. This report shall be updated annually to include  
1670 information for subsequent state fiscal years.

1671 (12) The division is authorized to make not more than  
1672 one (1) emergency extension of the contracts that are in effect on  
1673 July 1, 2021, with contractors who are receiving capitated  
1674 payments under a managed care delivery system established under  
1675 this subsection (H), as provided in this paragraph (12). The  
1676 maximum period of any such extension shall be one (1) year, and  
1677 under any such extensions, the contractors shall be subject to all  
1678 of the provisions of this subsection (H). The extended contracts  
1679 shall be revised to incorporate any provisions of this subsection  
1680 (H).

1681 (I) [Deleted]

1682 (J) There shall be no cuts in inpatient and outpatient  
1683 hospital payments, or allowable days or volumes, as long as the  
1684 hospital assessment provided in Section 43-13-145 is in effect.  
1685 This subsection (J) shall not apply to decreases in payments that  
1686 are a result of: reduced hospital admissions, audits or payments



1687 under the APR-DRG or APC models, or a managed care program or  
1688 similar model described in subsection (H) of this section.

1689 (K) In the negotiation and execution of such contracts  
1690 involving services performed by actuarial firms, the Executive  
1691 Director of the Division of Medicaid may negotiate a limitation on  
1692 liability to the state of prospective contractors.

1693 (L) The Division of Medicaid shall reimburse for services  
1694 provided to eligible Medicaid beneficiaries by a licensed birthing  
1695 center in a method and manner to be determined by the division in  
1696 accordance with federal laws and federal regulations. The  
1697 division shall seek any necessary waivers, make any required  
1698 amendments to its State Plan or revise any contracts authorized  
1699 under subsection (H) of this section as necessary to provide the  
1700 services authorized under this subsection. As used in this  
1701 subsection, the term "birthing centers" shall have the meaning as  
1702 defined in Section 41-77-1(a), which is a publicly or privately  
1703 owned facility, place or institution constructed, renovated,  
1704 leased or otherwise established where nonemergency births are  
1705 planned to occur away from the mother's usual residence following  
1706 a documented period of prenatal care for a normal uncomplicated  
1707 pregnancy which has been determined to be low risk through a  
1708 formal risk-scoring examination.

1709 (M) This section shall stand repealed on July 1, 2028.

1710 **SECTION 3.** Section 43-13-121, Mississippi Code of 1972, is  
1711 amended as follows:



1712 43-13-121. (1) The division shall administer the Medicaid  
1713 program under the provisions of this article, and may do the  
1714 following:

1715 (a) Adopt and promulgate reasonable rules, regulations  
1716 and standards, with approval of the Governor, and in accordance  
1717 with the Administrative Procedures Law, Section 25-43-1.101 et  
1718 seq.:

1719 (i) Establishing methods and procedures as may be  
1720 necessary for the proper and efficient administration of this  
1721 article;

1722 (ii) Providing Medicaid to all qualified  
1723 recipients under the provisions of this article as the division  
1724 may determine and within the limits of appropriated funds;

1725 (iii) Establishing reasonable fees, charges and  
1726 rates for medical services and drugs; in doing so, the division  
1727 shall fix all of those fees, charges and rates at the minimum  
1728 levels absolutely necessary to provide the medical assistance  
1729 authorized by this article, and shall not change any of those  
1730 fees, charges or rates except as may be authorized in Section  
1731 43-13-117;

1732 (iv) Providing for fair and impartial hearings;

1733 (v) Providing safeguards for preserving the  
1734 confidentiality of records; and

1735 (vi) For detecting and processing fraudulent  
1736 practices and abuses of the program;



1737                   (b) Receive and expend state, federal and other funds  
1738 in accordance with court judgments or settlements and agreements  
1739 between the State of Mississippi and the federal government, the  
1740 rules and regulations promulgated by the division, with the  
1741 approval of the Governor, and within the limitations and  
1742 restrictions of this article and within the limits of funds  
1743 available for that purpose;

1744                   (c) Subject to the limits imposed by this article and  
1745 subject to the provisions of subsection (8) of this section, to  
1746 submit a Medicaid plan to the United States Department of Health  
1747 and Human Services for approval under the provisions of the  
1748 federal Social Security Act, to act for the state in making  
1749 negotiations relative to the submission and approval of that plan,  
1750 to make such arrangements, not inconsistent with the law, as may  
1751 be required by or under federal law to obtain and retain that  
1752 approval and to secure for the state the benefits of the  
1753 provisions of that law.

1754                   No agreements, specifically including the general plan for  
1755 the operation of the Medicaid program in this state, shall be made  
1756 by and between the division and the United States Department of  
1757 Health and Human Services unless the Attorney General of the State  
1758 of Mississippi has reviewed the agreements, specifically including  
1759 the operational plan, and has certified in writing to the Governor  
1760 and to the executive director of the division that the agreements,



1761 including the plan of operation, have been drawn strictly in  
1762 accordance with the terms and requirements of this article;

1763 (d) In accordance with the purposes and intent of this  
1764 article and in compliance with its provisions, provide for aged  
1765 persons otherwise eligible for the benefits provided under Title  
1766 XVIII of the federal Social Security Act by expenditure of funds  
1767 available for those purposes;

1768 (e) To make reports to the United States Department of  
1769 Health and Human Services as from time to time may be required by  
1770 that federal department and to the Mississippi Legislature as  
1771 provided in this section;

1772 (f) Define and determine the scope, duration and amount  
1773 of Medicaid that may be provided in accordance with this article  
1774 and establish priorities therefor in conformity with this article;

1775 (g) Cooperate and contract with other state agencies  
1776 for the purpose of coordinating Medicaid provided under this  
1777 article and eliminating duplication and inefficiency in the  
1778 Medicaid program;

1779 (h) Adopt and use an official seal of the division;

1780 (i) Sue in its own name on behalf of the State of  
1781 Mississippi and employ legal counsel on a contingency basis with  
1782 the approval of the Attorney General;

1783 (j) To recover any and all payments incorrectly made by  
1784 the division to a recipient or provider from the recipient or  
1785 provider receiving the payments. The division shall be authorized



1786 to collect any overpayments to providers sixty (60) days after the  
1787 conclusion of any administrative appeal unless the matter is  
1788 appealed to a court of proper jurisdiction and bond is posted.  
1789 Any appeal filed after July 1, 2015, shall be to the Chancery  
1790 Court of the First Judicial District of Hinds County, Mississippi,  
1791 within sixty (60) days after the date that the division has  
1792 notified the provider by certified mail sent to the proper address  
1793 of the provider on file with the division and the provider has  
1794 signed for the certified mail notice, or sixty (60) days after the  
1795 date of the final decision if the provider does not sign for the  
1796 certified mail notice. To recover those payments, the division  
1797 may use the following methods, in addition to any other methods  
1798 available to the division:

1799 (i) The division shall report to the Department of  
1800 Revenue the name of any current or former Medicaid recipient who  
1801 has received medical services rendered during a period of  
1802 established Medicaid ineligibility and who has not reimbursed the  
1803 division for the related medical service payment(s). The  
1804 Department of Revenue shall withhold from the state tax refund of  
1805 the individual, and pay to the division, the amount of the  
1806 payment(s) for medical services rendered to the ineligible  
1807 individual that have not been reimbursed to the division for the  
1808 related medical service payment(s).

1809 (ii) The division shall report to the Department  
1810 of Revenue the name of any Medicaid provider to whom payments were





1811 incorrectly made that the division has not been able to recover by  
1812 other methods available to the division. The Department of  
1813 Revenue shall withhold from the state tax refund of the provider,  
1814 and pay to the division, the amount of the payments that were  
1815 incorrectly made to the provider that have not been recovered by  
1816 other available methods;

1817 (k) To recover any and all payments by the division  
1818 fraudulently obtained by a recipient or provider. Additionally,  
1819 if recovery of any payments fraudulently obtained by a recipient  
1820 or provider is made in any court, then, upon motion of the  
1821 Governor, the judge of the court may award twice the payments  
1822 recovered as damages;

1823 (l) Have full, complete and plenary power and authority  
1824 to conduct such investigations as it may deem necessary and  
1825 requisite of alleged or suspected violations or abuses of the  
1826 provisions of this article or of the regulations adopted under  
1827 this article, including, but not limited to, fraudulent or  
1828 unlawful act or deed by applicants for Medicaid or other benefits,  
1829 or payments made to any person, firm or corporation under the  
1830 terms, conditions and authority of this article, to suspend or  
1831 disqualify any provider of services, applicant or recipient for  
1832 gross abuse, fraudulent or unlawful acts for such periods,  
1833 including permanently, and under such conditions as the division  
1834 deems proper and just, including the imposition of a legal rate of  
1835 interest on the amount improperly or incorrectly paid. Recipients



1836 who are found to have misused or abused Medicaid benefits may be  
1837 locked into one (1) physician and/or one (1) pharmacy of the  
1838 recipient's choice for a reasonable amount of time in order to  
1839 educate and promote appropriate use of medical services, in  
1840 accordance with federal regulations. If an administrative hearing  
1841 becomes necessary, the division may, if the provider does not  
1842 succeed in his or her defense, tax the costs of the administrative  
1843 hearing, including the costs of the court reporter or stenographer  
1844 and transcript, to the provider. The convictions of a recipient  
1845 or a provider in a state or federal court for abuse, fraudulent or  
1846 unlawful acts under this chapter shall constitute an automatic  
1847 disqualification of the recipient or automatic disqualification of  
1848 the provider from participation under the Medicaid program.

1849 A conviction, for the purposes of this chapter, shall include  
1850 a judgment entered on a plea of nolo contendere or a  
1851 nonadjudicated guilty plea and shall have the same force as a  
1852 judgment entered pursuant to a guilty plea or a conviction  
1853 following trial. A certified copy of the judgment of the court of  
1854 competent jurisdiction of the conviction shall constitute prima  
1855 facie evidence of the conviction for disqualification purposes;

1856 (m) Establish and provide such methods of  
1857 administration as may be necessary for the proper and efficient  
1858 operation of the Medicaid program, fully utilizing computer  
1859 equipment as may be necessary to oversee and control all current  
1860 expenditures for purposes of this article, and to closely monitor



1861 and supervise all recipient payments and vendors rendering  
1862 services under this article. Notwithstanding any other provision  
1863 of state law, the division is authorized to enter into a ten-year  
1864 contract(s) with a vendor(s) to provide services described in this  
1865 paragraph (m). Notwithstanding any provision of law to the  
1866 contrary, the division is authorized to extend its Medicaid  
1867 Management Information System, including all related components  
1868 and services, and Decision Support System, including all related  
1869 components and services, contracts in effect on June 30, 2020, for  
1870 a period not to exceed two (2) years without complying with state  
1871 procurement regulations;

1872 (n) To cooperate and contract with the federal  
1873 government for the purpose of providing Medicaid to Vietnamese and  
1874 Cambodian refugees, under the provisions of Public Law 94-23 and  
1875 Public Law 94-24, including any amendments to those laws, only to  
1876 the extent that the Medicaid assistance and the administrative  
1877 cost related thereto are one hundred percent (100%) reimbursable  
1878 by the federal government. For the purposes of Section 43-13-117,  
1879 persons receiving Medicaid under Public Law 94-23 and Public Law  
1880 94-24, including any amendments to those laws, shall not be  
1881 considered a new group or category of recipient; and

1882 (o) The division shall impose penalties upon Medicaid  
1883 only, Title XIX participating long-term care facilities found to  
1884 be in noncompliance with division and certification standards in  
1885 accordance with federal and state regulations, including interest



1886 at the same rate calculated by the United States Department of  
1887 Health and Human Services and/or the Centers for Medicare and  
1888 Medicaid Services (CMS) under federal regulations.

1889 (2) The division also shall exercise such additional powers  
1890 and perform such other duties as may be conferred upon the  
1891 division by act of the Legislature.

1892 (3) The division, and the State Department of Health as the  
1893 agency for licensure of health care facilities and certification  
1894 and inspection for the Medicaid and/or Medicare programs, shall  
1895 contract for or otherwise provide for the consolidation of on-site  
1896 inspections of health care facilities that are necessitated by the  
1897 respective programs and functions of the division and the  
1898 department.

1899 (4) The division and its hearing officers shall have power  
1900 to preserve and enforce order during hearings; to issue subpoenas  
1901 for, to administer oaths to and to compel the attendance and  
1902 testimony of witnesses, or the production of books, papers,  
1903 documents and other evidence, or the taking of depositions before  
1904 any designated individual competent to administer oaths; to  
1905 examine witnesses; and to do all things conformable to law that  
1906 may be necessary to enable them effectively to discharge the  
1907 duties of their office. In compelling the attendance and  
1908 testimony of witnesses, or the production of books, papers,  
1909 documents and other evidence, or the taking of depositions, as  
1910 authorized by this section, the division or its hearing officers



1911 may designate an individual employed by the division or some other  
1912 suitable person to execute and return that process, whose action  
1913 in executing and returning that process shall be as lawful as if  
1914 done by the sheriff or some other proper officer authorized to  
1915 execute and return process in the county where the witness may  
1916 reside. In carrying out the investigatory powers under the  
1917 provisions of this article, the executive director or other  
1918 designated person or persons may examine, obtain, copy or  
1919 reproduce the books, papers, documents, medical charts,  
1920 prescriptions and other records relating to medical care and  
1921 services furnished by the provider to a recipient or designated  
1922 recipients of Medicaid services under investigation. In the  
1923 absence of the voluntary submission of the books, papers,  
1924 documents, medical charts, prescriptions and other records, the  
1925 Governor, the executive director, or other designated person may  
1926 issue and serve subpoenas instantly upon the provider, his or her  
1927 agent, servant or employee for the production of the books,  
1928 papers, documents, medical charts, prescriptions or other records  
1929 during an audit or investigation of the provider. If any provider  
1930 or his or her agent, servant or employee refuses to produce the  
1931 records after being duly subpoenaed, the executive director may  
1932 certify those facts and institute contempt proceedings in the  
1933 manner, time and place as authorized by law for administrative  
1934 proceedings. As an additional remedy, the division may recover  
1935 all amounts paid to the provider covering the period of the audit



1936 or investigation, inclusive of a legal rate of interest and a  
1937 reasonable attorney's fee and costs of court if suit becomes  
1938 necessary. Division staff shall have immediate access to the  
1939 provider's physical location, facilities, records, documents,  
1940 books, and any other records relating to medical care and services  
1941 rendered to recipients during regular business hours.

1942 (5) If any person in proceedings before the division  
1943 disobeys or resists any lawful order or process, or misbehaves  
1944 during a hearing or so near the place thereof as to obstruct the  
1945 hearing, or neglects to produce, after having been ordered to do  
1946 so, any pertinent book, paper or document, or refuses to appear  
1947 after having been subpoenaed, or upon appearing refuses to take  
1948 the oath as a witness, or after having taken the oath refuses to  
1949 be examined according to law, the executive director shall certify  
1950 the facts to any court having jurisdiction in the place in which  
1951 it is sitting, and the court shall thereupon, in a summary manner,  
1952 hear the evidence as to the acts complained of, and if the  
1953 evidence so warrants, punish that person in the same manner and to  
1954 the same extent as for a contempt committed before the court, or  
1955 commit that person upon the same condition as if the doing of the  
1956 forbidden act had occurred with reference to the process of, or in  
1957 the presence of, the court.

1958 (6) In suspending or terminating any provider from  
1959 participation in the Medicaid program, the division shall preclude  
1960 the provider from submitting claims for payment, either personally



1961 or through any clinic, group, corporation or other association to  
1962 the division or its fiscal agents for any services or supplies  
1963 provided under the Medicaid program except for those services or  
1964 supplies provided before the suspension or termination. No  
1965 clinic, group, corporation or other association that is a provider  
1966 of services shall submit claims for payment to the division or its  
1967 fiscal agents for any services or supplies provided by a person  
1968 within that organization who has been suspended or terminated from  
1969 participation in the Medicaid program except for those services or  
1970 supplies provided before the suspension or termination. When this  
1971 provision is violated by a provider of services that is a clinic,  
1972 group, corporation or other association, the division may suspend  
1973 or terminate that organization from participation. Suspension may  
1974 be applied by the division to all known affiliates of a provider,  
1975 provided that each decision to include an affiliate is made on a  
1976 case-by-case basis after giving due regard to all relevant facts  
1977 and circumstances. The violation, failure or inadequacy of  
1978 performance may be imputed to a person with whom the provider is  
1979 affiliated where that conduct was accomplished within the course  
1980 of his or her official duty or was effectuated by him or her with  
1981 the knowledge or approval of that person.

1982 (7) The division may deny or revoke enrollment in the  
1983 Medicaid program to a provider if any of the following are found  
1984 to be applicable to the provider, his or her agent, a managing



1985 employee or any person having an ownership interest equal to five  
1986 percent (5%) or greater in the provider:

1987 (a) Failure to truthfully or fully disclose any and all  
1988 information required, or the concealment of any and all  
1989 information required, on a claim, a provider application or a  
1990 provider agreement, or the making of a false or misleading  
1991 statement to the division relative to the Medicaid program.

1992 (b) Previous or current exclusion, suspension,  
1993 termination from or the involuntary withdrawing from participation  
1994 in the Medicaid program, any other state's Medicaid program,  
1995 Medicare or any other public or private health or health insurance  
1996 program. If the division ascertains that a provider has been  
1997 convicted of a felony under federal or state law for an offense  
1998 that the division determines is detrimental to the best interest  
1999 of the program or of Medicaid beneficiaries, the division may  
2000 refuse to enter into an agreement with that provider, or may  
2001 terminate or refuse to renew an existing agreement.

2002 (c) Conviction under federal or state law of a criminal  
2003 offense relating to the delivery of any goods, services or  
2004 supplies, including the performance of management or  
2005 administrative services relating to the delivery of the goods,  
2006 services or supplies, under the Medicaid program, any other  
2007 state's Medicaid program, Medicare or any other public or private  
2008 health or health insurance program.





2009 (d) Conviction under federal or state law of a criminal  
2010 offense relating to the neglect or abuse of a patient in  
2011 connection with the delivery of any goods, services or supplies.

2012 (e) Conviction under federal or state law of a criminal  
2013 offense relating to the unlawful manufacture, distribution,  
2014 prescription or dispensing of a controlled substance.

2015 (f) Conviction under federal or state law of a criminal  
2016 offense relating to fraud, theft, embezzlement, breach of  
2017 fiduciary responsibility or other financial misconduct.

2018 (g) Conviction under federal or state law of a criminal  
2019 offense punishable by imprisonment of a year or more that involves  
2020 moral turpitude, or acts against the elderly, children or infirm.

2021 (h) Conviction under federal or state law of a criminal  
2022 offense in connection with the interference or obstruction of any  
2023 investigation into any criminal offense listed in paragraphs (c)  
2024 through (i) of this subsection.

2025 (i) Sanction for a violation of federal or state laws  
2026 or rules relative to the Medicaid program, any other state's  
2027 Medicaid program, Medicare or any other public health care or  
2028 health insurance program.

2029 (j) Revocation of license or certification.

2030 (k) Failure to pay recovery properly assessed or  
2031 pursuant to an approved repayment schedule under the Medicaid  
2032 program.

2033 (l) Failure to meet any condition of enrollment.



2034 (8) (a) As used in this subsection (8), the following terms  
2035 shall be defined as provided in this paragraph, except as  
2036 otherwise provided in this subsection:

2037 (i) "Committees" means the Medicaid Committees of  
2038 the House of Representatives and the Senate, and "committee" means  
2039 either one of those committees.

2040 (ii) "State Plan" means the agreement between the  
2041 State of Mississippi and the federal government regarding the  
2042 nature and scope of Mississippi's Medicaid Program.

2043 (iii) "State Plan Amendment" means a change to the  
2044 State Plan, which must be approved by the Centers for Medicare and  
2045 Medicaid Services (CMS) before its implementation.

2046 (b) Whenever the Division of Medicaid proposes a State  
2047 Plan Amendment, the division shall give notice to the chairmen of  
2048 the committees at least thirty (30) calendar days, when possible,  
2049 before the proposed State Plan Amendment is filed with CMS. If  
2050 the division needs to expedite the thirty-day notice, the division  
2051 will notify both chairmen of that fact as soon as possible. The  
2052 division shall furnish the chairmen with a concise summary of each  
2053 proposed State Plan Amendment along with the notice, and shall  
2054 furnish the chairmen with a copy of any proposed State Plan  
2055 Amendment upon request. The division also shall provide a summary  
2056 and copy of any proposed State Plan Amendment to any other member  
2057 of the Legislature upon request.



2058                   (c) If the chairman of either committee or both  
2059 chairmen jointly object to the proposed State Plan Amendment or  
2060 any part thereof, the chairman or chairmen shall notify the  
2061 division and provide the reasons for their objection in writing  
2062 not later than seven (7) calendar days after receipt of the notice  
2063 from the division. The chairman or chairmen may make written  
2064 recommendations to the division for changes to be made to a  
2065 proposed State Plan Amendment.

2066                   (d) (i) The chairman of either committee or both  
2067 chairmen jointly may hold a committee meeting to review a proposed  
2068 State Plan Amendment. If either chairman or both chairmen decide  
2069 to hold a meeting, they shall notify the division of their  
2070 intention in writing within seven (7) calendar days after receipt  
2071 of the notice from the division, and shall set the date and time  
2072 for the meeting in their notice to the division, which shall not  
2073 be later than fourteen (14) calendar days after receipt of the  
2074 notice from the division.

2075                   (ii) After the committee meeting, the committee or  
2076 committees may object to the proposed State Plan Amendment or any  
2077 part thereof. The committee or committees shall notify the  
2078 division and the reasons for their objection in writing not later  
2079 than seven (7) calendar days after the meeting. The committee or  
2080 committees may make written recommendations to the division for  
2081 changes to be made to a proposed State Plan Amendment.



2082 (e) If both chairmen notify the division in writing  
2083 within seven (7) calendar days after receipt of the notice from  
2084 the division that they do not object to the proposed State Plan  
2085 Amendment and will not be holding a meeting to review the proposed  
2086 State Plan Amendment, the division may proceed to file the  
2087 proposed State Plan Amendment with CMS.

2088 (f) (i) If there are any objections to a proposed rate  
2089 change or any part thereof from either or both of the chairmen or  
2090 the committees, the division may withdraw the proposed State Plan  
2091 Amendment, make any of the recommended changes to the proposed  
2092 State Plan Amendment, or not make any changes to the proposed  
2093 State Plan Amendment.

2094 (ii) If the division does not make any changes to  
2095 the proposed State Plan Amendment, it shall notify the chairmen of  
2096 that fact in writing, and may proceed to file the State Plan  
2097 Amendment with CMS.

2098 (iii) If the division makes any changes to the  
2099 proposed State Plan Amendment, the division shall notify the  
2100 chairmen of its actions in writing, and may proceed to file the  
2101 State Plan Amendment with CMS.

2102 (g) Nothing in this subsection (8) shall be construed  
2103 as giving the chairmen or the committees any authority to veto,  
2104 nullify or revise any State Plan Amendment proposed by the  
2105 division. The authority of the chairmen or the committees under  
2106 this subsection shall be limited to reviewing, making objections



2107 to and making recommendations for changes to State Plan Amendments  
2108 proposed by the division.

2109 (i) If the division does not make any changes to  
2110 the proposed State Plan Amendment, it shall notify the chairmen of  
2111 that fact in writing, and may proceed to file the proposed State  
2112 Plan Amendment with CMS.

2113 (ii) If the division makes any changes to the  
2114 proposed State Plan Amendment, the division shall notify the  
2115 chairmen of the changes in writing, and may proceed to file the  
2116 proposed State Plan Amendment with CMS.

2117 (h) Nothing in this subsection (8) shall be construed  
2118 as giving the chairmen of the committees any authority to veto,  
2119 nullify or revise any State Plan Amendment proposed by the  
2120 division. The authority of the chairmen of the committees under  
2121 this subsection shall be limited to reviewing, making objections  
2122 to and making recommendations for suggested changes to State Plan  
2123 Amendments proposed by the division.

2124 **SECTION 4.** Section 43-13-305, Mississippi Code of 1972, is  
2125 amended as follows:

2126 43-13-305. (1) By accepting Medicaid from the Division of  
2127 Medicaid in the Office of the Governor, the recipient shall, to  
2128 the extent of the payment of medical expenses by the Division of  
2129 Medicaid, be deemed to have made an assignment to the Division of  
2130 Medicaid of any and all rights and interests in any third-party  
2131 benefits, hospitalization or indemnity contract or any cause of



2132 action, past, present or future, against any person, firm or  
2133 corporation for Medicaid benefits provided to the recipient by the  
2134 Division of Medicaid for injuries, disease or sickness caused or  
2135 suffered under circumstances creating a cause of action in favor  
2136 of the recipient against any such person, firm or corporation as  
2137 set out in Section 43-13-125. The recipient shall be deemed,  
2138 without the necessity of signing any document, to have appointed  
2139 the Division of Medicaid as his or her true and lawful  
2140 attorney-in-fact in his or her name, place and stead in collecting  
2141 any and all amounts due and owing for medical expenses paid by the  
2142 Division of Medicaid against such person, firm or corporation.

2143 (2) Whenever a provider of medical services or the Division  
2144 of Medicaid submits claims to an insurer on behalf of a Medicaid  
2145 recipient for whom an assignment of rights has been received, or  
2146 whose rights have been assigned by the operation of law, the  
2147 insurer must respond within sixty (60) days of receipt of a claim  
2148 by forwarding payment or issuing a notice of denial directly to  
2149 the submitter of the claim. The failure of the insuring entity to  
2150 comply with the provisions of this section shall subject the  
2151 insuring entity to recourse by the Division of Medicaid in  
2152 accordance with the provision of Section 43-13-315. In the case  
2153 of a responsible insurer, other than the insurers exempted under  
2154 federal law, that requires prior authorization for an item or  
2155 service furnished to a recipient, the insurer shall accept  
2156 authorization provided by the Division of Medicaid that the item



2157 or service is covered under the State Plan (or waiver of such  
2158 plan) for such recipient, as if such authorization were the prior  
2159 authorization made by the third party for such item or service.

2160 The Division of Medicaid shall be authorized to endorse any and  
2161 all, including, but not limited to, multi-payee checks, drafts,  
2162 money orders or other negotiable instruments representing Medicaid  
2163 payment recoveries that are received by the Division of Medicaid.

2164 (3) Court orders or agreements for medical support shall  
2165 direct such payments to the Division of Medicaid, which shall be  
2166 authorized to endorse any and all checks, drafts, money orders or  
2167 other negotiable instruments representing medical support payments  
2168 which are received. Any designated medical support funds received  
2169 by the State Department of Human Services or through its local  
2170 county departments shall be paid over to the Division of Medicaid.  
2171 When medical support for a Medicaid recipient is available through  
2172 an absent parent or custodial parent, the insuring entity shall  
2173 direct the medical support payment(s) to the provider of medical  
2174 services or to the Division of Medicaid.

2175 **SECTION 5.** Section 43-13-107, Mississippi Code of 1972, is  
2176 amended as follows:

2177 43-13-107. (1) The Division of Medicaid is created in the  
2178 Office of the Governor and established to administer this article  
2179 and perform such other duties as are prescribed by law.

2180 (2) (a) The Governor shall appoint a full-time executive  
2181 director, with the advice and consent of the Senate, who shall be



2182 either (i) a physician with administrative experience in a medical  
2183 care or health program, or (ii) a person holding a graduate degree  
2184 in medical care administration, public health, hospital  
2185 administration, or the equivalent, or (iii) a person holding a  
2186 bachelor's degree with at least three (3) years' experience in  
2187 management-level administration of, or policy development for,  
2188 Medicaid programs. Provided, however, no one who has been a  
2189 member of the Mississippi Legislature during the previous three  
2190 (3) years may be executive director. The executive director shall  
2191 be the official secretary and legal custodian of the records of  
2192 the division; shall be the agent of the division for the purpose  
2193 of receiving all service of process, summons and notices directed  
2194 to the division; shall perform such other duties as the Governor  
2195 may prescribe from time to time; and shall perform all other  
2196 duties that are now or may be imposed upon him or her by law.

2197 (b) The executive director shall serve at the will and  
2198 pleasure of the Governor.

2199 (c) The executive director shall, before entering upon  
2200 the discharge of the duties of the office, take and subscribe to  
2201 the oath of office prescribed by the Mississippi Constitution and  
2202 shall file the same in the Office of the Secretary of State, and  
2203 shall execute a bond in some surety company authorized to do  
2204 business in the state in the penal sum of One Hundred Thousand  
2205 Dollars (\$100,000.00), conditioned for the faithful and impartial  
2206 discharge of the duties of the office. The premium on the bond





2207 shall be paid as provided by law out of funds appropriated to the  
2208 Division of Medicaid for contractual services.

2209 (d) The executive director, with the approval of the  
2210 Governor and subject to the rules and regulations of the State  
2211 Personnel Board, shall employ such professional, administrative,  
2212 stenographic, secretarial, clerical and technical assistance as  
2213 may be necessary to perform the duties required in administering  
2214 this article and fix the compensation for those persons, all in  
2215 accordance with a state merit system meeting federal requirements.  
2216 When the salary of the executive director is not set by law, that  
2217 salary shall be set by the State Personnel Board. No employees of  
2218 the Division of Medicaid shall be considered to be staff members  
2219 of the immediate Office of the Governor; however, Section  
2220 25-9-107(c) (xv) shall apply to the executive director and other  
2221 administrative heads of the division.

2222 (3) (a) There is established a Medical Care Advisory  
2223 Committee, which shall be the committee that is required by  
2224 federal regulation to advise the Division of Medicaid about health  
2225 and medical care services.

2226 (b) The advisory committee shall consist of not less  
2227 than eleven (11) members, as follows:

2228 (i) The Governor shall appoint five (5) members,  
2229 one (1) from each congressional district and one (1) from the  
2230 state at large;



2231 (ii) The Lieutenant Governor shall appoint three  
2232 (3) members, one (1) from each Supreme Court district;

2233 (iii) The Speaker of the House of Representatives  
2234 shall appoint three (3) members, one (1) from each Supreme Court  
2235 district.

2236 All members appointed under this paragraph shall either be  
2237 health care providers or consumers of health care services. One  
2238 (1) member appointed by each of the appointing authorities shall  
2239 be a board-certified physician.

2240 (c) The respective Chairmen of the House Medicaid  
2241 Committee, the House Public Health and Human Services Committee,  
2242 the House Appropriations Committee, the Senate Medicaid Committee,  
2243 the Senate Public Health and Welfare Committee and the Senate  
2244 Appropriations Committee, or their designees, one (1) member of  
2245 the State Senate appointed by the Lieutenant Governor and one (1)  
2246 member of the House of Representatives appointed by the Speaker of  
2247 the House, shall serve as ex officio nonvoting members of the  
2248 advisory committee.

2249 (d) In addition to the committee members required by  
2250 paragraph (b), the advisory committee shall consist of such other  
2251 members as are necessary to meet the requirements of the federal  
2252 regulation applicable to the advisory committee, who shall be  
2253 appointed as provided in the federal regulation.



2254           (e) The chairmanship of the advisory committee shall be  
2255 elected by the voting members of the committee annually and shall  
2256 not serve more than two (2) consecutive years as chairman.

2257           (f) The members of the advisory committee specified in  
2258 paragraph (b) shall serve for terms that are concurrent with the  
2259 terms of members of the Legislature, and any member appointed  
2260 under paragraph (b) may be reappointed to the advisory committee.  
2261 The members of the advisory committee specified in paragraph (b)  
2262 shall serve without compensation, but shall receive reimbursement  
2263 to defray actual expenses incurred in the performance of committee  
2264 business as authorized by law. Legislators shall receive per diem  
2265 and expenses, which may be paid from the contingent expense funds  
2266 of their respective houses in the same amounts as provided for  
2267 committee meetings when the Legislature is not in session.

2268           (g) The advisory committee shall meet not less than  
2269 quarterly, and advisory committee members shall be furnished  
2270 written notice of the meetings at least ten (10) days before the  
2271 date of the meeting.

2272           (h) The executive director shall submit to the advisory  
2273 committee all amendments, modifications and changes to the state  
2274 plan for the operation of the Medicaid program, for review by the  
2275 advisory committee before the amendments, modifications or changes  
2276 may be implemented by the division.

2277           (i) The advisory committee, among its duties and  
2278 responsibilities, shall:



2279 (i) Advise the division with respect to  
2280 amendments, modifications and changes to the state plan for the  
2281 operation of the Medicaid program;

2282 (ii) Advise the division with respect to issues  
2283 concerning receipt and disbursement of funds and eligibility for  
2284 Medicaid;

2285 (iii) Advise the division with respect to  
2286 determining the quantity, quality and extent of medical care  
2287 provided under this article;

2288 (iv) Communicate the views of the medical care  
2289 professions to the division and communicate the views of the  
2290 division to the medical care professions;

2291 (v) Gather information on reasons that medical  
2292 care providers do not participate in the Medicaid program and  
2293 changes that could be made in the program to encourage more  
2294 providers to participate in the Medicaid program, and advise the  
2295 division with respect to encouraging physicians and other medical  
2296 care providers to participate in the Medicaid program;

2297 (vi) Provide a written report on or before  
2298 November 30 of each year to the Governor, Lieutenant Governor and  
2299 Speaker of the House of Representatives.

2300 (j) Effective July 9, 2025, there is established a  
2301 Medicaid Advisory Committee and Beneficiary Advisory Committee as  
2302 required pursuant to federal regulations. The Medicaid Advisory  
2303 Committee shall consist of no more than twenty (20) members. All



2304 members of the Medical Care Advisory Committee serving on January  
2305 1, 2025, shall be selected to serve on the Medicaid Advisory  
2306 Committee and such members shall serve until July 1, 2028. Such  
2307 members shall not be reappointed for immediately successive and  
2308 consecutive terms. If any such member resigns, then the division  
2309 shall replace the member for the remainder of the term. Other  
2310 members of the Medicaid Advisory Committee and Beneficiary  
2311 Advisory Committee shall be selected by the division consistent  
2312 with federal regulations. Committee member terms shall not be  
2313 followed immediately by a consecutive term for the same member, on  
2314 a rotating and continuous basis.

2315 (4) (a) There is established a Drug Use Review Board, which  
2316 shall be the board that is required by federal law to:

2317 (i) Review and initiate retrospective drug use,  
2318 review including ongoing periodic examination of claims data and  
2319 other records in order to identify patterns of fraud, abuse, gross  
2320 overuse, or inappropriate or medically unnecessary care, among  
2321 physicians, pharmacists and individuals receiving Medicaid  
2322 benefits or associated with specific drugs or groups of drugs.

2323 (ii) Review and initiate ongoing interventions for  
2324 physicians and pharmacists, targeted toward therapy problems or  
2325 individuals identified in the course of retrospective drug use  
2326 reviews.



2327 (iii) On an ongoing basis, assess data on drug use  
2328 against explicit predetermined standards using the compendia and  
2329 literature set forth in federal law and regulations.

2330 (b) The board shall consist of not less than twelve  
2331 (12) members appointed by the Governor, or his designee.

2332 (c) The board shall meet at least quarterly, and board  
2333 members shall be furnished written notice of the meetings at least  
2334 ten (10) days before the date of the meeting.

2335 (d) The board meetings shall be open to the public,  
2336 members of the press, legislators and consumers. Additionally,  
2337 all documents provided to board members shall be available to  
2338 members of the Legislature in the same manner, and shall be made  
2339 available to others for a reasonable fee for copying. However,  
2340 patient confidentiality and provider confidentiality shall be  
2341 protected by blinding patient names and provider names with  
2342 numerical or other anonymous identifiers. The board meetings  
2343 shall be subject to the Open Meetings Act (Sections 25-41-1  
2344 through 25-41-17). Board meetings conducted in violation of this  
2345 section shall be deemed unlawful.

2346 (5) (a) There is established a Pharmacy and Therapeutics  
2347 Committee, which shall be appointed by the Governor, or his  
2348 designee.

2349 (b) The committee shall meet as often as needed to  
2350 fulfill its responsibilities and obligations as set forth in this  
2351 section, and committee members shall be furnished written notice



2352 of the meetings at least ten (10) days before the date of the  
2353 meeting.

2354 (c) The committee meetings shall be open to the public,  
2355 members of the press, legislators and consumers. Additionally,  
2356 all documents provided to committee members shall be available to  
2357 members of the Legislature in the same manner, and shall be made  
2358 available to others for a reasonable fee for copying. However,  
2359 patient confidentiality and provider confidentiality shall be  
2360 protected by blinding patient names and provider names with  
2361 numerical or other anonymous identifiers. The committee meetings  
2362 shall be subject to the Open Meetings Act (Sections 25-41-1  
2363 through 25-41-17). Committee meetings conducted in violation of  
2364 this section shall be deemed unlawful.

2365 (d) After a thirty-day public notice, the executive  
2366 director, or his or her designee, shall present the division's  
2367 recommendation regarding prior approval for a therapeutic class of  
2368 drugs to the committee. However, in circumstances where the  
2369 division deems it necessary for the health and safety of Medicaid  
2370 beneficiaries, the division may present to the committee its  
2371 recommendations regarding a particular drug without a thirty-day  
2372 public notice. In making that presentation, the division shall  
2373 state to the committee the circumstances that precipitate the need  
2374 for the committee to review the status of a particular drug  
2375 without a thirty-day public notice. The committee may determine  
2376 whether or not to review the particular drug under the



2377 circumstances stated by the division without a thirty-day public  
2378 notice. If the committee determines to review the status of the  
2379 particular drug, it shall make its recommendations to the  
2380 division, after which the division shall file those  
2381 recommendations for a thirty-day public comment under Section  
2382 25-43-7(1).

2383 (e) Upon reviewing the information and recommendations,  
2384 the committee shall forward a written recommendation approved by a  
2385 majority of the committee to the executive director, or his or her  
2386 designee. The decisions of the committee regarding any  
2387 limitations to be imposed on any drug or its use for a specified  
2388 indication shall be based on sound clinical evidence found in  
2389 labeling, drug compendia, and peer-reviewed clinical literature  
2390 pertaining to use of the drug in the relevant population.

2391 (f) Upon reviewing and considering all recommendations  
2392 including recommendations of the committee, comments, and data,  
2393 the executive director shall make a final determination whether to  
2394 require prior approval of a therapeutic class of drugs, or modify  
2395 existing prior approval requirements for a therapeutic class of  
2396 drugs.

2397 (g) At least thirty (30) days before the executive  
2398 director implements new or amended prior authorization decisions,  
2399 written notice of the executive director's decision shall be  
2400 provided to all prescribing Medicaid providers, all Medicaid  
2401 enrolled pharmacies, and any other party who has requested the





2402 notification. However, notice given under Section 25-43-7(1) will  
2403 substitute for and meet the requirement for notice under this  
2404 subsection.

2405 (h) Members of the committee shall dispose of matters  
2406 before the committee in an unbiased and professional manner. If a  
2407 matter being considered by the committee presents a real or  
2408 apparent conflict of interest for any member of the committee,  
2409 that member shall disclose the conflict in writing to the  
2410 committee chair and recuse himself or herself from any discussions  
2411 and/or actions on the matter.

2412 **SECTION 6.** This act shall take effect and be in force from  
2413 and after July 1, 2025.

